

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING," IN PENCIL IN ITEM 18. GIVE PAGES 1, 2 AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

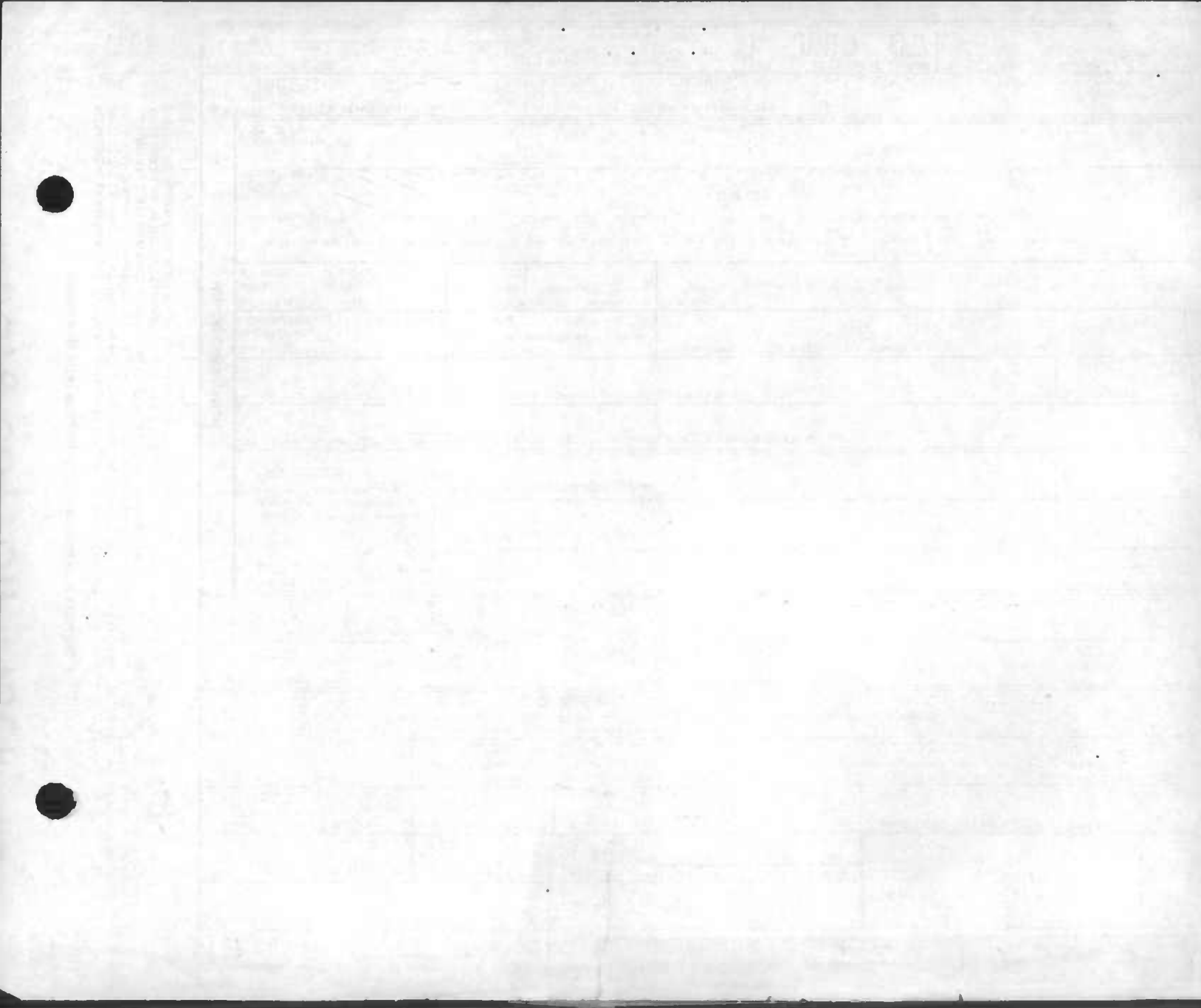
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Items, 18a. & 22a., 6-629, 7/25/87, by

 STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST Naim		MIDDLE G.		LAST Abou-Zolof		2a. DATE KNOWN OF DEATH ESTI. <input checked="" type="checkbox"/> MONTH DAY YEAR DEATH MATED <input type="checkbox"/> 6 5 19 87		2b. HOUR M 9:36P	
3. SEX male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 10 10 1963	6. AGE (IN YEARS) (a) BIRTHDAY 23 YRS	IF UNDER 1 YR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 6 5 1987		2d. HOUR M 9:36P			
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Kuwait		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD					
10. CITY OR TOWN OF DEATH Riverdale		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Leland Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Student		12b. KIND OF BUSINESS OR INDUSTRY Univ. of Maryland					
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 6016 South Port Dr.		20814	
14. FATHER'S NAME FIRST MIDDLE LAST George N. Abouzol		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lyla Hattab		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) N/A		16b. SOCIAL SECURITY NO. N/A		17. INFORMANT Amal G. Abou-zolof-sister-(same as 13e)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fatty change of liver</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>William M. Zane</i>		TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER						DATE SIGNED 6/6/87			
EXAMINER'S NAME (TYPE OR PRINT)		William M. Zane, M.D.						ADDRESS 111 Penn St. Balto.MD.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6-12-1987		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring Montgomery Md.					
24. FUNERAL DIRECTOR NAME ADDRESS Hines/Rinaldi Funeral Home 11800 N.H. Ave., Sil. Spring, Md.		25a. DATE REC'D. BY REGISTRAR JUN 9 1987		25b. REGISTRAR'S SIGNATURE <i>Julia D. ...</i>							



BP

DHMH - 16 50M 1/B1
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be completed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician only, it may be filed in the funeral director's office. Page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, item 2 must be attached to this certificate.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. DECEASED NAME (TYPE OR PRINT) EMMA C. ADAMS					2a. DATE OF DEATH MONTH DAY YEAR 06 03 87					2b. HOUR 7:25 PM	
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Dec 2, 1895		6. AGE (IN YEARS LAST BIRTHDAY) 91		7. IF UNDER 1 YEAR MONTHS DAYS YRS.		8. IF UNDER 24 HRS HOURS MIN. 7:25 PM	
7a. BIRTHPLACE COUNTRY Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES MD.					
10. CITY OR TOWN OF DEATH LINTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Md. Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Printer		12b. KIND OF BUSINESS OR INDUSTRY U.S. Gov			
13a. STATE Maryland		13b. COUNTY Charles		13c. CITY OR TOWN Waldorf		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Bx-192 Mattawomen-Beantown Rd/20601			
14. FATHER'S NAME FIRST MIDDLE LAST John William Adams					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Virginia Lee Delozier						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 214-42-5108		17. INFORMANT Joseph L. Burch		18. ADDRESS Bx-195 Mattawomen-Beantown Rd., Waldorf, Maryland 20601					
18. CAUSE OF DEATH (Enter only one cause per line for a, b, and c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF b) ADVANCED CARDIAC MYOPATHY 10 YEARS DUE TO, OR AS A CONSEQUENCE OF c) ADVANCED CORONARIES ARTERIOSCLEROSIS 15 YEARS											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from JAN. 1st 1980 to JUNE 3rd 1987 , that (I) (we) lost the deceased on JUNE 3rd 1987 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.											
22b. SIGNATURE Bluno Koleba, MD				DEGREE MD				22c. DATE SIGNED JUNE 4/87		22d. ADDRESS 4400 STAMP RD TEMPER MILLS-MD 20748	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 6/6/87		23c. NAME OF CEMETERY OR CREMATORY St. Paul's Cem		23d. LOCATION CITY OR TOWN COUNTY STATE Waldorf, Charles, Md.			
24. FUNERAL DIRECTOR NAME Hunt Funeral Home				P.O. Box 156 Waldorf, md 20601				25a. DATE REC'D. BY REGISTRAR JUN 5 1987			
25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>											

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 17948

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) AHMED HUSSEIN AHMED			2a. DATE OF DEATH MONTH DAY YEAR June 28 1987			2b. HOUR 7:25am				
3. SEX Male		4. RACE Egyptian		5. DATE OF BIRTH MONTH DAY YEAR August 2, 1923		6. AGE (IN YEARS LAST BIRTHDAY) 63 Years YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Egypt		7b. CITIZEN OF WHAT COUNTRY? Egypt		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD.				
10. CITY OR TOWN OF DEATH Lanham		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) AMI Doctors' Hospital of P.G. Co.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Accountant		12b. KIND OF BUSINESS OR INDUSTRY Embassy Oman		
13a. STATE Maryland		13b. COUNTY Prince Geo		13c. CITY OR TOWN CollegePk		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 5810 Bryn Mawr Rd, 20740		
14. FATHER'S NAME FIRST MIDDLE LAST Hussein Ahmed			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Amina Ali							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No			16b. SOCIAL SECURITY NO. 577-72-1683		17. INFORMANT Mrs. Rashida H. Ahmed (Same as # 13 above)				ADDRESS	
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Caschiae Arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pulmonary Edema</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Atherosclerotic heart disease</u>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Sepsis, Diabetes mellitus, acute respiratory failure, Anoxic encephalopathy</u>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>6-8</u> , 19 <u>87</u> , to <u>6-28</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>6-27</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death.)										
22b. SIGNATURE <u>Ravinder K. Rustagi</u>			DEGREE <u>MD</u>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RAVINDER K. RUSTAGI			22e. ADDRESS <u>6132 Landover Road</u> <u>Cheverly, Md 20785</u>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 6-29-1987		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood, Pr. Geo, Md.			
24. FUNERAL DIRECTOR NAME <u>St. Anthony's</u>			25a. ADDRESS <u>254 Carroll St.</u>		25b. DATE REC'D. BY REGISTRAR JUL 2 1987		25c. REGISTRAR'S SIGNATURE <u>Julia Tindler-Randall</u>			
25d. ADDRESS <u>Takoma Fun'l Home</u>			25e. ADDRESS <u>N.W., Wash, D.C. 20012</u>							

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 17949

1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Clifford W. Ahlquist			2a. DATE OF DEATH June 8, 1987			2b. HOUR 3:31P M			
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH 12 DAY 16 YEAR 1914		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Crosby, Minn.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges County MD			
10. CITY OR TOWN OF DEATH Laurel		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Greater Laurel Beltsville Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret.		12b. KIND OF BUSINESS OR INDUSTRY Construction	
13a. STATE Md.		13b. COUNTY P.G.		13c. CITY OR TOWN Laurel		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 15463 Arbory Way 20707	
14. FATHER'S NAME FIRST MIDDLE LAST John Ahlquist			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Amanda Koivisto						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. WWII 477-01-3885		17. INFORMANT ADDRESS Frances Ahlquist same as 13e					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiorespiratory Arrest</u> DUE TO, OR AS A CONSEQUENCE OF: (b) <u>Multiple Pulmonary Abscesses</u> DUE TO, OR AS A CONSEQUENCE OF: (c) <u>Severe Chronic Obstructive Pulmonary Disease</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. a									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>6/8</u> 19 <u>87</u> , to <u>6/8</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>6/8</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>W. Wanner</u>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>6/9/87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>W. Wanner</u>			22e. ADDRESS <u>321 Prince Georges St</u>			22f. CITY OR TOWN <u>Laurel</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 6/10/87		23c. NAME OF CEMETERY OR CREMATORY Balto. Wash. Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE <u>P.G. Md.</u>		
24. FUNERAL DIRECTOR NAME ADDRESS 7601 Sandy Spring Road Fleck Funeral Home, Inc. Laurel, Md. 20707						25a. DATE RECEIVED BY REGISTRAR <u>JUN 12 1987</u>		25b. REGISTRAR'S SIGNATURE <u>Julia Barber</u>	

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

7 1 1 9 5 0

REG. NO.

FOR
STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Frances Ella Allen			2a DATE OF DEATH MONTH DAY YEAR 6-3-87		2b HOUR 11:45 AM				
3 SEX Female		4 RACE Caucasian		5 DATE OF BIRTH MONTH DAY YEAR Feb. 7, 1910		6 AGE (IN YEARS LAST BIRTHDAY) 77 YRS IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD.			
10 CITY OR TOWN OF DEATH Greenbelt		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Greenbelt Nursing Center			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b KIND OF BUSINESS OR INDUSTRY Own Home		
13a STATE Maryland		13b COUNTY P.G.		13c CITY OR TOWN Cheverly		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 5906 Forest Road 20785	
14 FATHER'S NAME FIRST MIDDLE LAST Charles Ball			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hattie McPherson			16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b SOCIAL SECURITY NO. 579-28-1653	
17 INFORMANT Robert E. Allen (Son) Bowie, Maryland 20715			ADDRESS 2804 Bosworth Lane			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 min			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ACUTE CARDIO PULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) GERMINATING ARTERIO SCLEROSIS DUE TO, OR AS A CONSEQUENCE OF (c) SENILITY									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: WOUND TRACT INFECTION									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from 5-21-87 , 19____, to 6-3-87 , 19____, that (I) (we) lost saw the deceased alive on 5-21-87 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.									
22b SIGNATURE [Signature]		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 6-3-87			
22d PHYSICIAN'S NAME (TYPE OR PRINT) ANDROS C. WANA		22e ADDRESS 1306 KENNEDY-SWAMP RD, HYATTSVILLE							
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 06/05/87		23c NAME OF CEMETERY OR CREMATORY Washington National Cem. Suitland P.C. Maryland		23d LOCATION CITY OR TOWN COUNTY STATE			
24a FUNERAL DIRECTOR Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Avenue Hyattsville, Md. 20781				25a DATE REC'D. BY REGISTRAR JUN 8 1987					
25b REGISTRAR'S SIGNATURE [Signature]									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

Handwritten text at the top of the page, possibly a header or title, including the word "REPORT".

Handwritten text in the upper middle section, including the word "REPORT" and some numbers.

Handwritten text in the middle section, including the word "REPORT" and some numbers.

Handwritten text in the lower middle section, including the word "REPORT" and some numbers.

Handwritten text in the lower section, including the word "REPORT" and some numbers.

Handwritten text at the bottom of the page, including the word "REPORT" and some numbers.

Handwritten text at the very bottom of the page, including the word "REPORT" and some numbers.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 17951

FOR
1- STATE
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) EUGENE W. ALTICE			2a DATE OF DEATH MONTH DAY YEAR 06-21-87			2b HOUR 4:45PM			
3 SEX Male		4 RACE Black		5 DATE OF BIRTH MONTH DAY YEAR 7 18 52		6 AGE (IN YEARS LAST BIRTHDAY) 34 YRS.		6 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash., D.C.		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S MD.			
10 CITY OR TOWN OF DEATH CHEVERLY		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE'S HOSPITAL CENTER				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Unemployed		12b KIND OF BUSINESS OR INDUSTRY None	
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Md.		13b COUNTY PRINCE GEORGE'S		13c CITY OR TOWN Forestville		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 2021 Brooks Drive 20747	
14 FATHER'S NAME FIRST MIDDLE LAST Clovis W. Altice			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Geraldine Tircuit						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO. 578-72-8572		17 INFORMANT Mr. Clovis W. Altice/father/same as 13e					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardio Respiratory Failure</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Overwhelming GA-VE SEPSIS</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>KLBSIELLA Pneumonia</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>Leukopenia, Liver dysfunction, R/O HTLV III Infection</u>									
19a DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE, FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from <u>6/17/87</u> , to <u>6/21/87</u> , that (I) (we) lost saw the deceased alive on <u>6/21/87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b SIGNATURE <u>IC. Raymond Ahmed</u>						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c DATE SIGNED <u>6/22/87</u>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <u>KHATA AHMED</u>						22e ADDRESS <u>1 HOSPITAL DR., CHEVERLY, MD</u>			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b DATE 6-25-87		23c NAME OF CEMETERY OR CREMATORY Lincoln Memorial		23d LOCATION CITY OR TOWN COUNTY STATE Suitland, Md.		
24 FUNERAL DIRECTOR NAME John T. Rhines Co. 3015 12th St. N.E., D.C. 20017						25 FILE REC'D. BY REGISTRAR JUN 25 1987 <u>Julia D. ...</u>			

THURSDAY

10. 12. 1911

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THURSDAY

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it is completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 87 17952	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST FRANCES A. BADER						2a. DATE OF DEATH MONTH DAY YEAR 06/12/87			2b. HOUR 9:27P M		
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR OCT. 10, 1923		6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE MD.					
10. CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGES MEDICAL CENTER				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY AT HOME			
13a. STATE Md.		13b. COUNTY P.G.C.		13c. CITY OR TOWN W. HYATTSVILLE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 2637 NICHOLSON ST. 20782			
14. FATHER'S NAME FIRST MIDDLE LAST LOWELL BLAKE				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANN COLLADAY							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -----		17. INFORMANT JOSEPH A. BADER		ADDRESS (SAME AS ITEM #13) (SAME AS ITEM #13)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Adenocarcinoma of Liver</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>Liver failure. Renal failure.</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Atherosclerotic heart disease</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Alcohol abuse. Diabetes.</u>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>5-28</u> , 19 <u>87</u> , to <u>6-12</u> , 19 <u>87</u> , that (I) (we) lost saw the deceased <u>above</u> , (I) (we) (did not) <u>view the body after death</u> .											
22b. SIGNATURE <u>Rahmen Tuli</u>				DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 6-17-1987	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RAHMEN TULI, MD				22e. ADDRESS 3601 TAYLOR ST. BRENTWOOD, MD 20722							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE 6-17-1987		23c. NAME OF CEMETERY OR CREMATORY CHAMBERS CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE RIVERDALE, P.G.C. Md.					
24. FUNERAL DIRECTOR NAME W. W. CHAMBERS CO. INC.				ADDRESS RIVERDALE, Md. 20737		25a. DATE REC'D. BY REGISTRAR JUN 23 1987		25b. REGISTRAR'S SIGNATURE			

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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DHMH - 17
(VR A15 ME (5))

Item 21a., 6-631, by Med. Exam., 9/3/87, STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR
1- STATE
REGISTRAR Gbj.

REG. NO. 1 7 9 5 3

1 DECEASED NAME (TYPE OR PRINT) CHARLES M. BAILLEY			2a DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 6 27 19 87		2b HOUR M 3:17 PM
3 SEX Male	4 RACE White	5 DATE OF BIRTH MONTH DAY YEAR July 12 14 72	6 AGE IN YEARS BIRTHDAY YRS. MONTHS DAYS HOURS MIN	7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington DC	7b CITIZEN OF WHAT COUNTRY? USA
8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD		10 CITY OR TOWN OF DEATH Upper Marlboro	
11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3007 Eton Dr.		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mechanic		12b KIND OF BUSINESS OR INDUSTRY Water Pump	
13a STATE Maryland		13b COUNTY Pr George		13c CITY OR TOWN Up Marlboro	
14 FATHER'S NAME FIRST MIDDLE LAST Phillip Mackin Bailley		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bertha Mackin		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No	
16b SOCIAL SECURITY NO. 577 03 0201		17 INFORMANT Charles M Bailley, Jr		17 ADDRESS Same as #13	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Drowning DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?		20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 10 6-27- 19 87		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR 10 6-27- 19 87		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Subject fell into well.	
21d INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> well		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) well		21f LOCATION STREET CITY OR TOWN COUNTY STATE 3007 Eton Dr., Upper Marlboro, Prince George's MD	
22a I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>Dennis F. Smyth</i>		TITLE (SPECIFY) Assistant		DATE SIGNED 6-28-87	
EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D.		ADDRESS 111 Penn St., Balto., MD 21201			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b DATE 30 June 87		23c NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory	
23d LOCATION CITY OR TOWN COUNTY STATE Suitland Maryland		24 FUNERAL DIRECTOR NAME ADDRESS Robert E Wilhelm Funeral Home Suitland Maryland		25a DATE REC'D BY REGISTRAR JUL 06 1987	
25b REGISTRAR'S SIGNATURE <i>John Wilson</i>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 17954

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
DECEASED NAME (TYPE OR PRINT)		DATE		HOUR	
REGINALD M. BAILEY		June 8, 1987		2:30 A.M.	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YEAR	
Male	Black	Oct. 26, 1909	77	MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
Virginia	USA		Prince Georges' MD		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY		
Lanham	AMI Doctors Hospital	Retired-Post	Office		
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE	
Maryland	Seat Pleasant		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	723 Carrington Place 20743	
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME	16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			
Josiah Bailey	Cecelia Jordan	no			
16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS			
231 10 9730	Mary Bailey-Daughter-	9763 Good Luck Rd			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) Cerebro-Vascular Accident					
DUE TO, OR AS A CONSEQUENCE OF (b) Atro Sclerosis					
DUE TO, OR AS A CONSEQUENCE OF (c) Coma					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: Chron Renal Failure					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 5:15, 1987, to 6:8, 1987, that (I) (we) last saw the deceased alive on 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) later (did not) view the body after death.					
22b. SIGNATURE				22c. DATE SIGNED	
Rishpal Singh MD MRCP				6-9-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS	
RISHPAL SINGH				7525 Greenway Center Drive GREENBELT MD	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN		
Burial	June 13, 1987	Maryland National Memorial Park	Laurel, Maryland		
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR	
Stewart Funeral Home 4001 Beanning Road, NE				JUN 24 1987	
				25b. REGISTRAR'S SIGNATURE	
				Julia Davidson-Rodgers	

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059078 JUL 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 17955

1- FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) Joseph Mauchly Barber						2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 6 21 1987			2b. HOUR 9A		
3. SEX M	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 7-12-32	6. AGE (IN YEARS) (LAST BIRTHDAY) 54 YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 6 21 1987			2d. HOUR 10:15AM		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD					
10. CITY OR TOWN OF DEATH Glen Arden			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1414 - 8th Street			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Supervisor			12b. KIND OF BUSINESS OR INDUSTRY Computer		
13. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE MD		13b. COUNTY Prince Georges		13c. CITY OR TOWN Glen Arden		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1414 - 8th Street			
14. FATHER'S NAME FIRST MIDDLE LAST George T. Barber						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Christabel Woods					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 578-46-0837		17. INFORMANT ADDRESS Glen Arden., Debra Smith-1415 3rd St., Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) myocardial infarction										minutes	
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost											
(b) Arteriosclerotic Cardiovascular Disease										years	
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1											
None											
19a. DATE OF OPERATION None				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) None					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE Paul A DeVore MD TITLE (SPECIFY) M.D. Deputy MEDICAL EXAMINER DATE SIGNED 6-21-87											
EXAMINER'S NAME (TYPE OR PRINT) PAUL A DEVORE MD ADDRESS 4203 Greenshorne Rd Hyattsville, MD											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE 6/26/87		23c. NAME OF CEMETERY OR CREMATORY RESURRECTION CEM.				23d. LOCATION CITY OR TOWN COUNTY STATE CLINTON MD.	
24. FUNERAL DIRECTOR NAME H.S. Washington & Sons ADDRESS 4925 Bunnheads Avenue						25a. DATE RECEIVED BY REGISTRAR JUL 8 1987		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

15-15-8

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

DATE 10-15-8 BY SP-10A/ML

DATE 10-15-8

BY

SP-10A/ML

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DATE 10-15-8

BY SP-10A/ML

DATE 10-15-8

BY

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then present to the funeral home. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or filled in, it shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 17956

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
RAY B BARNEY		6-20-87		1.45A M	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	7. BALTIMORE CITY OR COUNTY OF DEATH	
Female	White	April 13, 1919	68 YRS	PRINCE GEORGE MD.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
Washington, D.C.	U.S.A.		PRINCE GEORGE		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY		
CHEVERLY	PRINCE GEORGE'S MEDICAL CENTER	Keypunch Operator	U.S. Government		
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE	
Maryland	Pr. Geo.	Hyattsville	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	7404 Varnum Street/20784-2312	
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME	16. SOCIAL SECURITY NO.			
Samuel Burnside	Adah Kimmel	RD 1, Box 118			
17a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	17b. SOCIAL SECURITY NO.	17. INFORMANT			
No	577-18-4284	Roberta Naugle/Seward, Pennsylvania 15954			
18. CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY					
IMMEDIATE CAUSE (a) <u>Sepsis</u>					
DUE TO, OR AS A CONSEQUENCE OF					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					
b) <u>Diabetes Mellitus</u>					
DUE TO, OR AS A CONSEQUENCE OF					
c) <u>Ischemic Cardiomyopathy</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>Coronary Heart Disease</u>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
	HOUR A.M. MONTH DAY YEAR				
	P.M. 19				
21d. INJURY OCCURRED	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION			
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>6-19-87</u> to <u>6-19-87</u> , that (I) (we) lost saw the deceased alive on <u>6-19-87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
<u>S.C. Gupta</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		6-20-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
S.C. Gupta, M.D.		8503 Perry Street, Mt. Ranier, MD 20822			
23a. BURIAL, CREMATION, REMOVAL (CHECK)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION		
Burial	6-23-87	Md. Veterans Cemetery	Cheltenham, Pr. Geo. Maryland		
24. FUNERAL DIRECTOR		25a. DATE REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Rendon-Hale Lanham Funeral Home		JUN 23 1987			
2013 Annapolis Road, Lanham, Maryland 20706					

THE UNIVERSITY OF CHICAGO

DEPARTMENT OF CHEMISTRY

LABORATORY OF ORGANIC CHEMISTRY

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 17957

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
VIRGINIA NORMA BARRICKMAN				06-24-87		6:20AM			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR	
Female		Caucasian		MONTH DAY YEAR Sept. 3, 1907		79		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
West Virginia		USA				PRINCE GEORGE'S COUNTY MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
CHEVERLY		GLADYS NOON SPELLMAN NUR. CARE CTR				Housewife		Home	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
Maryland		Pr. Georges Ft. Wash.				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME							
George		Howdershelt		Sarah Jane Montgomery					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
no		235-44-4771		Martha G. Frazier		same as #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>Cancer - Pulmonary artery</u>									
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									
(b) <u>organic brain disease</u>									
DUE TO, OR AS A CONSEQUENCE OF									
(c) <u>Parkinson's disease</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>recurrent urinary tract infection.</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)					
		HOUR A.M. MONTH DAY YEAR P.M. 19							
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f. LOCATION		CITY OR TOWN		COUNTY STATE	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				STREET					
22a. I certify that (I) (this hospital) attended the deceased from 10/22, 1986 to 6-24, 1987, that (I) (we) last saw the deceased alive on 6-24, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death.)									
22b. SIGNATURE				DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
R. Arora				M.D.				6/26/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS					
Rakesh Arora MD				14300 Gallant Fox Lane, Bowie, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION			
Burial		6-29-87		East Oak Grove		Morgantown Monongalia WVA			
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
NAME ADDRESS Hunt Funeral Home Waldorf, Md. 20601				JUN 26 1987		Julia Davidson-Randall			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETURN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 17958	
1. DECEASED NAME (TYPE OR PRINT) MARCELLUS Marcellos Bassant										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH 6 DAY 24 YEAR 1987	2b. HOUR 3P M
3. SEX M	4. RACE Black	5. DATE OF BIRTH MONTH 2 DAY 25 YEAR 39	6. AGE (IN YEARS) (LAST BIRTHDAY) 48 YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD MONTH 6 DAY 24 YEAR 1987	2d. HOUR 4P M				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) GUYANA		7b. CITIZEN OF WHAT COUNTRY? GUYANA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD					
10. CITY OR TOWN OF DEATH LAUREL		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 609 4th Street				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) heavy equip. operator		12b. KIND OF BUSINESS OR INDUSTRY private			
13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE MD COUNTY PRINCE GEORGES		13b. CITY OR TOWN LAUREL		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS 609 4th Street		13e. CITY OR TOWN LAUREL			
14. FATHER'S NAME FIRST Wolford MIDDLE Bassant LAST Bassant		15. MOTHER'S MAIDEN NAME FIRST Ursilla MIDDLE Bassant LAST Persaud									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 217-11-9813		17. INFORMANT Bibi Zabeda Bassant		ADDRESS					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxiation (hanging) DUE TO, OR AS A CONSEQUENCE OF SUICIDE Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) SUICIDE DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: None											
19a. DATE OF OPERATION N/A		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) N/A							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an autopsy <input type="checkbox"/> inspection <input checked="" type="checkbox"/> inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE Paul A DeVore MD		TITLE (SPECIFY) Deputy		M.D. Deputy		MEDICAL EXAMINER		DATE SIGNED 6/24/87			
EXAMINER'S NAME (TYPE OR PRINT) PAUL A DEVORE, MD		ADDRESS 4203 QUEENSBURY RD HYATTSVILLE MD									
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE 6/26/87		23c. NAME OF CEMETERY OR CREMATORY George Washington Cemetery		23d. LOCATION Adelphi Prince George MD					
24. FUNERAL DIRECTOR Donald V. Borgwardt		ADDRESS 4400 Powder Mill Rd Beltsville Md 20705		25a. DATE REC'D. BY REGISTRAR JUN 29 1987		25b. REGISTRAR'S SIGNATURE Julia Davidson-Bassant					

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(VR A15 ME (5))

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 17959

FOR
1- STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Leonard Perry Bazzle			2a. DATE OF DEATH MONTH DAY YEAR 6-16-87		2b. HOUR 12:01 PM		
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Feb. 8, 1908		6. AGE (IN YEARS LAST BIRTHDAY) 79	
7a. BIRTHPLACE Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S MD	
10. CITY OR TOWN OF DEATH Clinton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Mary's Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Insurance		12b. KIND OF BUSINESS OR INDUSTRY Self-employed	
13a. STATE Maryland		13b. COUNTY P.G.		13c. CITY OR TOWN Clinton		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME Oscar		15. MOTHER'S MAIDEN NAME Lena Mae Holsinger		13e. STREET ADDRESS / ZIP CODE #714		13f. STREET ADDRESS / ZIP CODE 8200 Mike Shapiro Dr. 20735	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? No		16b. SOCIAL SECURITY NO. N/A		17. INFORMANT Donald Bazzle		17. ADDRESS Rt 2 Box 175 White Plands Md	
18. CAUSE OF DEATH (Enter only one cause per line for a, b, and c) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) ACUTE MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF (c) CORONARY ARTERY DISEASE							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a CARDIOMECHALY							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from 5/15/87 to 6/16/87 , that (1) (we) last saw the deceased alive on 6/16/87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>[Signature]</i>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 6/17/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Charles A. McHann				22e. ADDRESS 8926 Woodland Rd Clinton MD 20735			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 06/19/87		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood Prince George's Md	
24. FUNERAL DIRECTOR Lee Funeral Home, Inc.				25a. DATE REC'D. BY REGISTRAR JUN 24 1987		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	
6633 Old Alexander Ferry Rd. Clinton, Md 20735							

MEDICAL CERTIFICATION



200% COTTON FIBER
J. H. M. & S. O. M.

056556

Items, 18a. & Part II., 21a. -22a., G-628, STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 17960

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE KNOWN OF DEATH			2b. DATE ESTIMATED			2c. DATE PRONOUNCED DEAD			2d. DATE OF DEATH			2e. HOUR		
FIRST MIDDLE LAST Goorie Sankar Beharry			MONTH DAY YEAR 5-30 1987			MONTH DAY YEAR 5-30 1987			MONTH DAY YEAR 5-30 1987			MONTH DAY YEAR 5-30 1987			M		
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS)			7. IF UNDER 1 YR			8. IF UNDER 24 HRS		
Male			Black			June 3, 1950			37 YRS								
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED			9. NEVER MARRIED			10. WIDOWED			11. DIVORCED		
Trinidad, WI			USA			<input checked="" type="checkbox"/>			<input type="checkbox"/>			<input type="checkbox"/>			<input type="checkbox"/>		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			13. BALTIMORE CITY OR COUNTY OF DEATH			14. BALTIMORE CITY OR COUNTY OF DEATH		
Beltsville			11228 Evans Trail			Mechanic						Prince George's County MD					
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS			13f. STREET ADDRESS		
Maryland			Prince George			Beltsville			YES <input type="checkbox"/> NO <input type="checkbox"/>			11228 Evans Trail			20705		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES?			16b. SOCIAL SECURITY NO.			17. INFORMANT			18. ADDRESS		
FIRST MIDDLE LAST Deo Beharry			FIRST MIDDLE LAST Patie Phagoonie			YES <input type="checkbox"/> NO <input type="checkbox"/>			142 52 2987			Deborah Durgadeen-friend-1907 Merri-			mac Drive, Adelphi, Md		
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			20. PART I DEATH WAS CAUSED BY:			21. IMMEDIATE CAUSE (a)			22. DUE TO, OR AS A CONSEQUENCE OF			23. CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a) STATING THE UNDERLYING CAUSE LAST			24. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
Gunshot wound of chest			mac Drive, Adelphi, Md			Gunshot wound of chest											
25. PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1			26. Cutting wound of left arm			27. DATE OF OPERATION			28. CONDITION FOR WHICH OPERATION WAS PERFORMED?			29. AUTOPSY?			30. YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
27. DATE OF OPERATION			28. CONDITION FOR WHICH OPERATION WAS PERFORMED?			29. AUTOPSY?			30. YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			31. 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR PRIMARY <input type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			32. 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		
												? P.M. 5 30 1987			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
												self/inflicted					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION			21g. CITY OR TOWN			21h. COUNTY			21i. STATE		
apartment			11228 Evans Trail Apt. I-1,			Beltsville,			Maryland								
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from:			Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			23. ACTUAL SIGNATURE			24. TITLE (SPECIFY)			25. DATE SIGNED			26. DATE		
Margarita A. Korell			M.D. Assistant			5-31-87											
27. EXAMINER'S NAME (TYPE OR PRINT)			28. ADDRESS			29. MARGARITA A. KORELL, M.D.			111 Penn St., Balto., MD 21201								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION			23e. COUNTY			23f. STATE		
Burial			June 5, 1987			Promise Land Cemetery			Appomattox, Virginia								
24. FUNERAL DIRECTOR NAME			25. DATE REC'D. BY REGISTRAR			25a. REGISTRAR'S SIGNATURE			25b. REGISTRAR'S SIGNATURE			25c. REGISTRAR'S SIGNATURE			25d. REGISTRAR'S SIGNATURE		
Stewart Funeral Home-4001 Benning Road,			JUN 8 1987			Julia Tindon-Rodgers											

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL. TRANSIT PERMIT. PAGES 4 AND 5 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
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(VR A15 ME (5))

March 1

1890

20% COTTON FIBER

2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified and a necropsy performed.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR		8717961		REG. NO.					
1 DECEASED NAME (TYPE OR PRINT) THOMAS L. BENDER, JR.				2a DATE OF DEATH MONTH DAY YEAR JUNE 8 1987		2b HOUR 10:30p ^m			
3 SEX Male		4 RACE Caucasian		5 DATE OF BIRTH MONTH DAY YEAR March 4 1922		6 AGE (IN YEARS LAST BIRTHDAY) 65 YRS		7 UNDER 1 YEAR IF UNDER 24 HRS MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Colorado		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD			
10 CITY OR TOWN OF DEATH Camp Springs		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Malcolm Grow Medical Center		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Air Force - Ret.		12b KIND OF BUSINESS OR INDUSTRY Military			
13a STATE Maryland		13b COUNTY Prince George		13c CITY OR TOWN Temple Hills		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 4204 Brinkley Road 20748	
14 FATHER'S NAME FIRST MIDDLE LAST Thomas L. Bender, Sr.				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Grace Sheff					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b SOCIAL SECURITY NO. 1942 - 1969 522-22-8089		17. INFORMANT ADDRESS June E. Bender 4204 Brinkley Rd. Temple Hills, Maryland					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CARDIORESPIRATORY ARREST</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									
DUE TO, OR AS A CONSEQUENCE OF (b) <u>RENAL FAILURE</u>									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>19 MARCH</u> , 19 <u>87</u> , to <u>8 JUNE</u> , 19 <u>87</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>8 JUNE</u> , 19 <u>87</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.									
22b SIGNATURE <i>John V. Ingari</i>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 8 JUNE 87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) JOHN V. INGARI, CAPT, USAF, MC				22e ADDRESS MALCOLM GROW USAF MED CEN AAFB, MD 20331					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 6/16/87		23c NAME OF CEMETERY OR CREMATORY Arlington Nat'l. Cem.		23d LOCATION CITY OR TOWN COUNTY STATE Arlington Virginia			
24 FUNERAL DIRECTOR NAME George P. Kalas Funeral Home				6160 Oxon Hill Rd. Oxon Hill, Md.		25a DATE REC'D. BY REGISTRAR JUN 11 1987		25b REGISTRAR'S SIGNATURE <i>Julia Bender-Randall</i>	

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 17962

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Elsie M. Biggs			2a. DATE OF DEATH MONTH DAY YEAR 6 1 87		2b. HOUR 9:11P ^M
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR Dec. 1 1910		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges Co MD.	
10. CITY OR TOWN OF DEATH Clinton	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) So. Maryland Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	12b. KIND OF BUSINESS OR INDUSTRY N/A	
13a. STATE Maryland	13b. COUNTY Prince George	13c. CITY OR TOWN Temple Hills	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 5505 Brinkley Rd / 20748	
14. FATHER'S NAME FIRST MIDDLE LAST Thomas B. Hardy		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Charlotte Ann Seaborn			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 577-68-9201		17. INFORMANT ADDRESS Betty J. Mastracco 8101 Arundel Dr. Ft. Washington, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Aspiration Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Congestive Heart Failure</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) this hospital attended the deceased from <u>5-31</u> , 19 <u>87</u> , to <u>6-1</u> , 19 <u>87</u> , that (I) viewed ^{saw} the deceased alive on <u>6-1</u> , 19 <u>87</u> , and that in (my) own ^{own} opinion death occurred on the date and hour and from the causes stated above, (I) will ^{did} not view the body after death.					
22b. SIGNATURE <u>M. Mostaan</u>		DEGREE		22c. DATE SIGNED <u>6/2/87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) M. Mostaan, M.D.		22e. ADDRESS 4235 - 28th Ave. Temple Hills, Md. 20748			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6/4/87	23c. NAME OF CEMETERY OR CREMATORY Washington Nat'l. Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland P.G. Maryland
24. FUNERAL DIRECTOR NAME George P. Kalas Funeral Home		ADDRESS 6160 Oxon Hill Rd Oxon Hill, Md.		25a. DATE REC'D BY REGISTRAR JUN 4 1987	25b. REGISTRAR'S SIGNATURE <u>Julia Sanders-Randall</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 should be kept with page 2 for 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner shall be notified at once.

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 17963

REG. NO.

1 FOR STATE REGISTRAR		2a DATE OF DEATH MONTH DAY YEAR		2b HOUR	
1 DECEASED NAME (TYPE OR PRINT)		3 SEX		4 RACE	
JOSEF Rudolf BIGLER		MALE		WHITE	
5 DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)		7a BIRTHPLACE (STATE OR FOREIGN)	
November 3, 1923		63 YRS		Austria	
8 CITIZEN OF WHAT COUNTRY?		9 BALTIMORE CITY OR COUNTY OF DEATH		10 CITY OR TOWN OF DEATH	
Austria		Prince Georges County, MD.		Forestville	
11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY	
2811 Birkle Lane		Admin. Officer		German Embassy	
13a STATE		13b COUNTY		13c CITY OR TOWN	
Maryland		Pr. Geo.		Forestville	
14 FATHER'S NAME FIRST MIDDLE LAST		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)	
Josef Anton Bigler		Amalie Leitgeb		NO --	
16b SOCIAL SECURITY NO		17 INFORMANT ADDRESS		18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SQUAMOUS CELL CARCINOMA Rt. Tonsellar Fossa (4-84) DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)	
None		Elisabeth Bigler Same as #13			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES NO	
21a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from June 17, 1987, to June 24, 1987, that (I) saw the deceased alive on June 17, 1987, and that in (my) opinion death occurred on the date and hour and from the causes stated above, (I) (did not) view the body after death.					
22b SIGNATURE DEGREE		22c DATE SIGNED		22d PHYSICIAN'S NAME (TYPE OR PRINT)	
Albert E. Rolle, M.D.		June 24, 1987		3800 Reservoir Rd., N.W. Wash., D.C. 20007	
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE		23c NAME OF CEMETERY OR CREMATORY	
Burial		27 June 1987		RESURRECTION CEMETERY Clinton PG Md	
24 FUNERAL DIRECTOR NAME		25a DATE REC'D. BY REGISTRAR		25b REGISTRAR'S SIGNATURE	
Robert E Wilhelm Funeral Home		JUN 30 1987		[Signature]	

Form with multiple sections and fields, including a header area with a date field and a main body with several rows of data. The text is faint and mostly illegible due to the quality of the scan. The form appears to be a standard administrative or financial document.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8717964
REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT) FRANCIS WILLIAM BORCHERT		JUNE 15, 1987		11:34pm	
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR Nov 22, 1920		6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD.	
10. CITY OR TOWN OF DEATH Andrews A.F.B.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Malcolm Grow Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret Military		12b. KIND OF BUSINESS OR INDUSTRY U.S. Air Force
13a. STATE Maryland	13b. COUNTY St. Mary's	13c. CITY OR TOWN Mechanicsville	13d. INSIDE CITY LIMITS? <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE Rt-5 Box-222 / 20659	
14. FATHER'S NAME FIRST MIDDLE LAST Charles Francis William Borchert		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Hughes			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. WW-II 132-07-7801		17. INFORMANT ADDRESS Eva Borchert (Wife) -Same as #13-	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY COLLAPSE</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>PNEUMONIA</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>AMYOTROPHIC LATERAL SCLEROSIS</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 14 JUNE 1987, to 15 JUNE 1987, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 15 JUNE 1987, and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) view the body after death.					
22b. SIGNATURE <i>Peter B. Mapes</i>		DEGREE MD		22c. DATE SIGNED 15 JUNE 87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) PETER B MAPES, CAPT, USAF, MC		22e. ADDRESS MALCOLM GROW USAF MED CEN AAFB, MD 20331			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 6/20/87	23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Central City, Somerset, Pa.	
24. FUNERAL DIRECTOR NAME Huntt Funeral Home		P.O. Box 156 Waldorf, Md 20601		25a. DATE REC'D. BY REGISTRAR JUN 18 1987	
		25b. REGISTRAR'S SIGNATURE			

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CLIFFMAN DUND

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055762 JUN 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 17965

1- FOR STATE REGISTRAR			2a. DATE KNOWN OF DEATH			2b. HOUR		
1 DECEASED NAME (TYPE OR PRINT)			2c. DATE PRONOUNCED DEAD			2d. HOUR		
Lois Marie Borden			6-4 1987			879A		
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.			
Female	White	March 14, 1925	62 YRS.					
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH			
Ohio	U.S.A.				Prince George's MD			
10 CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF IN SUCH FACILITY, GIVE STREET ADDRESS)			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY		
Clinton	8502 Weimar Court			Ret'd Secretary		U.S. Govt.		
13a STATE			13b COUNTY	13c CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e STREET ADDRESS		
Maryland			Prince George's	Clinton	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	8502 Weimar Court 20735		
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME					
Charles Wycoff			Neva Call					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b SOCIAL SECURITY NO.		17 INFORMANT (husband)		ADDRESS	
no			n/a		Thomas W. Borden		same as 13 a - e	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								
PART I DEATH WAS CAUSED BY:								
IMMEDIATE CAUSE (a) <i>Adenocarcinoma of colon</i>								
DUE TO, OR AS A CONSEQUENCE OF								
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:								
(b)								
DUE TO, OR AS A CONSEQUENCE OF								
(c)								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1								
<i>Hypertensive cardiac vasculodisease, Aortic valve replacement</i>								
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY?		
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
			P.M. 19					
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f LOCATION			
					CITY OR TOWN COUNTY STATE			
22a I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion								
ACTUAL SIGNATURE			TIME (SPECIFY)			DATE SIGNED		
<i>Augusta P. Rodriguez</i>			M.D. <i>Deputy</i>			6-4-87		
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS					
<i>Thomas W. Borden</i>			<i>5009 Ray Hunt Ct. Cp Sp. Md 20746</i>					
23a BURIAL, CREMATION, REMOVAL (SPECIFY)			23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION	
Burial			June 8, 1987		Arlington National Cem.		Arlington, VA	
24 FUNERAL DIRECTOR NAME			25a DATE REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE			
Lee Funeral Home, Inc.			JUN 5 1987		<i>Julia Davidson-Randall</i>			
6633 Old Alexander Ferry Rd., Clinton, MD 20735								

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORN EXAM. 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25MBP
DHMH - 17
(VR A15 ME)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked (1) or (2), show pay injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MABEL MIDDLE Eva LAST Boyer			2a. DATE OF DEATH MONTH DAY YEAR 6/21 8/			2b. HOUR 1:30 PM					
3. SEX F		4. RACE WT		5. DATE OF BIRTH MONTH DAY YEAR 7/28 01		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD					
10. CITY OR TOWN OF DEATH Hyattsville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carroll Manor Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) House Wife		12b. KIND OF BUSINESS OR INDUSTRY Own Home			
13a. STATE Maryland			13b. COUNTY Prince Geo.		13c. CITY OR TOWN Hyattsville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 5509 43rd Ave. 20781		
14. FATHER'S NAME FIRST MIDDLE LAST Charles Weyandt			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lydia Schaeffer			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No				16b. SOCIAL SECURITY NO. 217-42-3008	
17. INFORMANT 145 Pine Crest Rd. Carl F. Boyer (son) Annapolis, MD 21403											

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>IMMEDIATE</u>	
DUE TO, OR AS A CONSEQUENCE OF (b) <u>CEREBROVASCULAR ACCIDENT (STROKE)</u>		2 DAYS	
DUE TO, OR AS A CONSEQUENCE OF (c) _____			

PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from <u>6/16</u> 19 <u>87</u> , to <u>6/21</u> 19 <u>87</u> , that (1) <input checked="" type="checkbox"/> I saw the deceased alive on <u>6/16</u> 19 <u>87</u> , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (1) <input type="checkbox"/> we did not view the body after death.							
22b. SIGNATURE <u>Kevin G. Nealon, M.D.</u>				DEGREE		22c. DATE SIGNED <u>6/21/87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>KEVIN G. NEALON, M.D.</u>				22e. ADDRESS <u>916 19th ST. N.W. WASH, D.C. 20006</u>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 06/25/87		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood Prince George's MD	
24. FUNERAL DIRECTOR Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Ave, Hyattsville, MD 20781						25. DATE REC'D. BY REGISTRAR JUN 23 1987	
						26. REGISTRAR'S SIGNATURE <u>Julia Gordon-Randall</u>	

THE UNIVERSITY OF CHICAGO
LIBRARY

RECEIVED
JAN 10 1964
LIBRARY

THE UNIVERSITY OF CHICAGO
LIBRARY
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THE UNIVERSITY OF CHICAGO
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LIBRARY

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH
















FOR
1- STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Louise M. Breslin			2a. DATE OF DEATH MONTH DAY YEAR 6 12 87		2b. HOUR 4:45 P.
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR December 15, 1913		6. AGE (IN YEARS LAST BIRTHDAY) 73	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD.	
10. CITY OR TOWN OF DEATH Cheverly	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Prince Georges Medical Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Beautician		12b. KIND OF BUSINESS OR INDUSTRY Self Employed
13a. STATE Maryland	13b. CITY OR TOWN Prince Geo.	13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 1814 Powhatan St. 20784		
14. FATHER'S NAME FIRST MIDDLE LAST John Wilford Merkel		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Minnie Bell Waycaster			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 577-03-9360A		17. INFORMANT ADDRESS Robert M. Taft 37140 Torres Avenue Barstow, California 92311	
18. CAUSE OF DEATH - Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatitis DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 months					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a Cirrhosis of liver					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) this hospital attended the deceased from 6/11 19 87 , to 6/12 19 87 that (1) (he) last saw the deceased alive on 6/11 19 87 , and that (2) (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) did (did not) view the body after death.					
22b. SIGNATURE Nelson G. Goodman DEGREE				22c. DATE SIGNED 6/13/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Nelson G. Goodman				22e. ADDRESS 3231 Superior Lane Bowie, Md. 20715	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE June 14, 1987		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crem.	
23d. LOCATION (CITY OR TOWN) Alexandria		23e. COUNTY Virginia		23f. STATE Virginia	
24a. NAME OF FUNERAL HOME Francis Gasch's Sons Funeral Home, P.A.				24b. ADDRESS 4739 Baltimore Ave. Hyattsville, MD 20781	
25a. DATE REC'D. BY REGISTRAR JUN 17 1987				25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and accepted by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1. STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) DONNA LEE BRIZZI			2a. DATE OF DEATH MONTH DAY YEAR JUNE 1 1987			2b. HOUR 6:00P M		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR March 23, 1952		6. AGE (IN YEARS LAST BIRTHDAY) 35 YRS. MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD.		
10. CITY OR TOWN OF DEATH Lanham		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Doctors' Hospital of Pr. Geo. Co.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home		
13a. STATE Maryland			13b. COUNTY Pr. Geo.		13c. CITY OR TOWN Seabrook		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST William F. Collins, Sr.			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Edith R. Powell					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 223-80-0892		17. INFORMANT 7005 Woodstream Terrace Edward A. Brizzi/Seabrook, Maryland 20706			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CARDIO-RESPIRATORY ARREST</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		(b) <u>MASSIVE PULMONARY EMBOLISM</u>	
DUE TO, OR AS A CONSEQUENCE OF		(c) <u>LEFT SUBCLAVIAN VEIN THROMBOSIS</u>	

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I <u>STATUS POST-CHOLECYSTECTOMY, ACUTE PANCREATITIS</u>			
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19a. DATE OF OPERATION 5-2-87		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Cholecystitis and cholelithiasis		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			

22a. I certify that (I) (this hospital) attended the deceased from <u>4-30</u> 19 <u>87</u> to <u>6-1</u> 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>6-1</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.	
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22b. SIGNATURE <u>R. Longoria, M.D.</u>		DEGREE		22c. DATE SIGNED 6-2-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Ricardo Longoria, M.D.		22e. ADDRESS 6201 Greenbelt Rd., M-17, College Park, Md.			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6-5-87		23c. NAME OF CEMETERY OR CREMATORY Md. Veterans Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Cheltenham, Pr. Geo. Maryland	
24. FUNERAL DIRECTOR NAME ADDRESS Rendon-Hale Lanham Funeral Home 9013 Annapolis Rd, Lanham, Maryland 20706				25a. DATE REC'D. BY REGISTRAR JUN 8 1987			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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Items, 18a. & 22a., G-629, by Med. Exam., STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
1- STATE 7/25/87, / Gbj.
REGISTRAR
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a DATE KNOWN OF DEATH		MONTH		DAY		YEAR		2b HOUR	
Theodora Patrenella Brookman								ESTIMATED <input checked="" type="checkbox"/>		6/		19/		1987		10:28 P	
3 SEX	4 RACE	5 DATE OF BIRTH		6 AGE		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c DATE PRONOUNCED DEAD		MONTH		DAY		YEAR	
Female	White	10 18 50		36						6/		19/		1987			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH											
Holland		Holland				Prince George's County, MD											
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY											
Laurel		Greater Laurel/Beltsville Hospital		Sec.		Trucking											
13a STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS		13e STREET AND NO.									
Md.		P.G.		Laurel		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		210 11th Street		20707							
14 FATHER'S NAME		15 MOTHER'S MAIDEN NAME															
Leonardus Zegstroof		Grietje Bouwknecht															
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b SOCIAL SECURITY NO.		17 INFORMANT		ADDRESS											
no		214-54-9431		Earson Brookman		same as 13e											
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))																	
PART I DEATH WAS CAUSED BY:																	
IMMEDIATE CAUSE (a) Seizure disorder																	
DUE TO, OR AS A CONSEQUENCE OF																	
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:																	
(b) DUE TO, OR AS A CONSEQUENCE OF																	
(c)																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I																	
19a DATE OF OPERATION																	
19b CONDITION FOR WHICH OPERATION WAS PERFORMED?																	
20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																	
21a EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH																	
21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR																	
21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)																	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>																	
21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)																	
21f LOCATION STREET CITY OR TOWN COUNTY STATE																	
22a I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE Charles P. Rokes, M.D. TITLE (SPECIFY) Assistant MEDICAL EXAMINER DATE SIGNED 6/20/87																	
EXAMINER'S NAME (TYPE OR PRINT) Charles P. Rokes, M.D. ADDRESS 111 Penn St.																	
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial 23b DATE 6/23/87 23c NAME OF CEMETERY OR CREMATORY Union Cemetery 23d LOCATION Burtonsville Mont. Md.																	
24 FUNERAL DIRECTOR Fleck Funeral Home, Inc. 7601 Sandy Spr. Rd. Laurel, Md. 20707 25a DATE REC'D. BY REGISTRAR JUN 25 1987 25b REGISTRAR'S SIGNATURE Julia Davidson-Randall																	

DIVISION OF VITAL RECORDS, 201 W. PRESIDENT ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PRINCIPLE IN ITEM 18, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM BM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESIDENT STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M

DHMH - 17
(VR A15 ME (5))

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FOR COTTON FIBER
WATER
ECONOMY

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 87 17970

FOR 1 - STATE REGISTRAR		1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST RUBY GERTRUDE BROOKS		2a DATE OF DEATH MONTH DAY YEAR JUNE 05 1987		2b HOUR 4:40a M	
3 SEX Female		4 RACE Black		5 DATE OF BIRTH MONTH DAY YEAR October 22, 1914		6 AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN. 72 YRS.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b CITIZEN OF WHAT COUNTRY? United States		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD.	
10 CITY OR TOWN OF DEATH Camp Springs		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Malcom Grow Medical Center		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Crossing guard		12b KIND OF BUSINESS OR INDUSTRY County schools	
13a STATE Maryland		13b COUNTY Pr. Georges		13c CITY OR TOWN Seat Pleasant		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e STREET ADDRESS / ZIP CODE 7305 Joplin Street, 20743		14 FATHER'S NAME FIRST MIDDLE LAST Reginald Headley		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Gertrude Lynch			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 068-01-2550		17 INFORMANT ADDRESS Nathaniel G. Brooks, 7305 Joplin Street			
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>METASTATIC LUNG CARCINOMA</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH _____							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a _____							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>23 MAY</u> , 19 <u>87</u> , to <u>05 Jun</u> , 19 <u>87</u> , that <input checked="" type="checkbox"/> (we) lost <input type="checkbox"/> saw the deceased alive on <u>05 JUN</u> , 19 <u>87</u> and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did <input type="checkbox"/> view the body after death.							
22b SIGNATURE Donald W Rumbaugh		DEGREE MD		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c DATE SIGNED 5 June 87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) DONALD W RUMBAUGH, MD		22e ADDRESS MALCOLM GROW USAFMC, ANDREWS AFB MD 20331					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 6/10/87		23c NAME OF CEMETERY OR CREMATORY Arlington Natl. Cem.		23d LOCATION CITY OR TOWN COUNTY STATE Ft. Myer, Arlington, Virginia	
24 FUNERAL DIRECTOR -NAME McGuire Funeral Service, 7400 Georgia Ave. N.W.		ADDRESS Washington, DC		25a DATE REC'D. BY REGISTRAR JUN 9 1987		25b REGISTRAR'S SIGNATURE Julia Davidson-Randall	

LEONARDO LINDLEY BOLANOS* 1908-1982

Figure 1

012705

[illegible]

3

040-04-3220

18070074 18070074

2017/03/09

2579

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17971
REG NO

1. DECEASED NAME (TYPE OR PRINT) Bradley Maxfield Brown			2a. DATE OF DEATH KNOWN OF ESTI- MATED <input checked="" type="checkbox"/> 6/19/1987			2b. HOUR 8:15 P M		
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR 2 23 1967	6. AGE (IN YEARS) LAST BIRTHDAY 20 YRS.	IF UNDER 1 YR MONTHS DAYS HOURS MIN	IF UNDER 24 HRS	7c. DATE PRONOUNCED DEAD 6/19/1987		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County, MD		
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Prince George's General Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Student		12b. KIND OF BUSINESS OR INDUSTRY None	
13a. STATE Virginia		13b. COUNTY Fairfax		13c. CITY OR TOWN Springfield		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
13e. STREET ADDRESS 79999		13f. CITY OR TOWN Springfield		13g. STREET ADDRESS 7902 Larrick Court (22153)				
14. FATHER'S NAME FIRST MIDDLE LAST Philip M Brown			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Barbara N Varney					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No			16b. SOCIAL SECURITY NO. 223-17-1646			17. INFORMANT Philip Brown 7902 Larrick Ct Springfield VA		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Injuries DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 7:23 AM 6/19/1987		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject driver of jeep/auto collision			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) roadway		21f. LOCATION STREET CITY OR TOWN COUNTY STATE Northbound Rt. #95, Forestville, Pr. Geo., Md.			
22a. I certify that I took charge of the remains described above, held on death resulted from <input type="checkbox"/> Natural causes <input checked="" type="checkbox"/> Accidents <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion								
ACTUAL SIGNATURE Charles P. Kokes, M.D.			TITLE (SPECIFY) M.D. Assistant			DATE SIGNED 6/20/87		
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS 111 Penn St.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 6/22/87		23c. NAME OF CEMETERY OR CREMATORY FAIRFAX MEMORIAL PARK		23d. LOCATION CITY OR TOWN COUNTY STATE FAIRFAX, VIRGINIA		
24. FUNERAL DIRECTOR NAME ADDRESS DEMAINE FUNERAL HOMES, INC ALEXANDRIA, VA				25a. DATE REC'D BY REGISTRAR JUN 27 1987		25b. REGISTRAR'S SIGNATURE		

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL, ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER. PAGES 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

07-84
25M
DHMH - 17
(VR A15 ME (5))

20% COTTON FIBER

CHIEFTAIN BOND



28180-0000

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

67 17972

REG. NO.

1. FOR
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ROSINA BROWN			2a. DATE OF DEATH MONTH DAY YEAR 06 07 87		2b. HOUR 4 50AM
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Aug 26, 1919		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 72 HRS. HOURS MIN.
7a. BIRTHPLACE (COUNTRY) Switzerland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES COUNTY MD.	
10. CITY OR TOWN OF DEATH CHEVERLY	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGES MEDICAL CENTER		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Not Known		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Maryland	13b. COUNTY Pr George	13c. CITY OR TOWN Upper Marlboro	13d. INSIDE CITY LIMITS? NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 1077 Largo Road 20772	
14. FATHER'S NAME FIRST MIDDLE LAST Not Known		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Not Known			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 223-46-4471	17. INFORMANT James W Neal 8510 Connecticut Ave Chevy Chase, Md 20815			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio Pulmonary arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Renal Carcinoma with Metastasis DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 6-4-1987, to 6-4-1987, that (I) (we) lost saw the deceased alive on 6-4-1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Sudhir K. Julka		DEGREE M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> RESIDENT STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 6-7-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SUDHIR K. JULKA		22e. ADDRESS P.G. GEN. HOSPITAL, CHEVERLY, MD 20785			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation	23b. DATE 12Junel987	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory	23d. LOCATION CITY OR TOWN COUNTY STATE Suitland PG Md	25a. DATE REC'D. BY REGISTRAR JUN 16 1987	
24. FUNERAL DIRECTOR NAME Robert E Wilhelm Funeral Home		ADDRESS Suitland, Md.		25b. REGISTRAR'S SIGNATURE Julia Sinden-Rudner	

TO HOSPITAL OR ATTENDING PHYSICIAN: This certificate must be completed and signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transfer permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Returned by the Med. Examiner

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use on the burial transit permit. Then please remember to return the certificate to the Division of Vital Records with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 1B shows any injury, or other pathological event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1 DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
FIRST MIDDLE LAST		MONTH DAY YEAR		M	
LUCILLE Rita BRUNGO		6-30-87		1.55A.M.	
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR	
Female	White	MONTH DAY YEAR	74 YRS	IF UNDER 24 HRS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH		
Nebraska	U.S.A.		PRINCE GEORGES COUNTY MD		
10 CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY
CHEVERLY	PRINCE GEORGES MEDICAL CENTER		Housewife		Own Home
13a STATE		13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS?	
Maryland	P.G.	Hyattsville	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET ADDRESS / ZIP CODE	
14 FATHER'S NAME		15 MOTHER'S MAIDEN NAME		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)	
FIRST MIDDLE LAST		FIRST MIDDLE LAST		16b SOCIAL SECURITY NO	
Joseph F. Reznicek		Anna F. Pavel		505-22-2094	
17 INFORMANT (Husband)		ADDRESS			
Samuel Anthony Brungo		6706 Newport Road Hyattsville, Md. 20784			
18 CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c):					
PART I. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) <u>Toxic Encephalopathy</u> 4 days.					
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic heart infarction</u> 5 days.					
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cerebrovascular Accident</u> 2 months.					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)	
		HOUR A.M. MONTH DAY YEAR			
		P.M. 19			
21d INJURY OCCURRED		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)		21f LOCATION	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from <u>29 Jun 87</u> to <u>30 Jun 87</u> that (I) <u>last</u> saw the deceased alive on <u>29 Jun 87</u> and that in (my) <u>best</u> opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (did not) view the body after death.					
22b SIGNATURE		DEGREE		22c DATE SIGNED	
<u>Thomas G. Maloney, Jr., M.D.</u>		<u>M.D.</u>		6-30-87	
22d PHYSICIAN'S NAME (TYPE OR PRINT)		22e ADDRESS			
Thomas G. Maloney, Jr., M.D.		4814 71st Avenue Hyattsville, Md. 20784			
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE		23c NAME OF CEMETERY OR CREMATORY	
Burial		6/30/87		Gate of Heaven Cemetery Silver Spring Mont. Md.	
24 FUNERAL HOME		25a DATE REC'D. BY REGISTRAR		25b REGISTRAR'S SIGNATURE	
Francis Gasch's Sons Funeral Home, P.A.		JUL 06 1987		<u>Julia Davidson-Randall</u>	
4739 Baltimore Avenue Hyattsville, Md. 20781					

Film G631 item 5 9/17/87 rja

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) ELMO BARRON BRYAN			2a. DATE OF DEATH June 10, 1987		2b. HOUR 11:49a _M	
3. SEX Male	4. RACE White	5. DATE OF BIRTH March 12, 1914		6. AGE (IN YEARS LAST BIRTHDAY) 73	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE Georgia	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD.		
10. CITY OR TOWN OF DEATH Lanham	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) AMI Doctors' Hosp. of Pr. Geo. Co.		12. USUAL OCCUPATION Assistant Director		12b. KIND OF BUSINESS OR INDUSTRY U.S. Govt	
13a. USUAL RESIDENCE Maryland	13b. COUNTY P.G.	13c. CITY OR TOWN Cheverly	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 3117 Cheverly Avenue 20785		
4. FATHER'S NAME Leon C. Bryan		15. MOTHER'S MAIDEN NAME Bertha Barron				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? No		16b. SOCIAL SECURITY NO. 215-44-7914		17. INFORMANT James R. Bryan (Son) Landover, Md. 20784		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Arteriosclerotic Cardiovascular Disease 20 yrs</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <i>and Chronic Obstructive Pulmonary Disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Diabetes Mellitus, type II</i>						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (1) (this hospital) attended the decedent from <i>Sept 1960</i> to <i>June 10, 1987</i> and that (2) my opinion death occurred on the date and hour and from the causes stated						
22b. SIGNATURE <i>William D. Rosson</i>		22c. DATE SIGNED <i>6/12/87</i>		22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		
22e. PHYSICIAN'S NAME (TYPE OR PRINT) WILLIAM D. ROSSON, M.D.		22f. ADDRESS 5701 - 85th Avenue New Carrollton, Md.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 06/16/87		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood P.G. Maryland
24. FUNERAL HOME Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Avenue Hyattsville, Md. 20781				25a. DATE REC'D. BY REGISTRAR JUN 17 1987		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 48 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the health certificate must be certified or attested.

BP

Released by Med. Examiner to PMD

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The funeral director should be notified of the death of the deceased within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified of once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 17975

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MABEL B. BUFFERT		2a. DATE OF DEATH MONTH DAY YEAR JUNE 25, 1987		2b. HOUR 4:35 PM	
3. SEX FEMALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR APRIL 2, 1925	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) RALEIGH, N.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. AGE (IN YEARS (LAST BIRTHDAY)) 62 YRS.	
10. CITY OR TOWN OF DEATH LANHAM, MD.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) AMI DOCTORS' HOSPITAL P.G. Co.		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES COUNTY MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) REAL ESTATE		12b. KIND OF BUSINESS OR INDUSTRY PRIVATE		13a. STREET ADDRESS / ZIP CODE 5207 Whitfield Chapel, Lanham 20706	
14. FATHER'S NAME FIRST MIDDLE LAST SAUL BUMPERS		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LISA JAMES		16. SOCIAL SECURITY NO. 998-51-4036	
17. INFORMANT ADDRESS ALTON EVANS SAME ADDRESS		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Heart Failure</i>		APPROXIMATE INTERVAL BETWEEN CAUSE 1 AND DEATH	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>6/25</i> 19 <i>87</i> , to <i>6/25</i> 19 <i>87</i> , that (I) (we) lost saw the deceased alive on <i>6/25</i> 19 <i>87</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE <i>R. J. Feldman</i>		22c. DATE SIGNED <i>6/25/87</i>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 6-30-87		23c. NAME OF CEMETERY OR CREMATORY HARMONY MEMORIAL	
24. FUNERAL DIRECTOR NAME JOHNSON & JENKINS FH		25a. DATE REC'D. BY REGISTRAR JUL 02 1987		25b. REGISTRAR'S SIGNATURE <i>W. R. Landell</i>	

MEDICAL CERTIFICATION

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1

Chronic Heart Failure, recurrent pleural effusion

6.7.1934

Don't know by whom

was

(1.1.1)

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Only one person known from

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH													
1. FOR STATE REGISTRAR		7 7 1 7 9 7 6		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
JANE C BURROUGHS				06		11		87		5		00P M	
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
FEMALE		BLACK		MONTH DAY YEAR 01 18 15		72		YRS		MONTHS		DAYS	
7a. BIRTHPLACE STATE OR FOREIGN COUNTRY		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH							
Md.		U.S.A.				PRINCE GEORGE'S MD.							
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR OCCUPATION	
CHEVERLY				PRINCE GEORGE'S HOSPITAL CENTER				Ret. Steam Table Builders					
13a. STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE			
Md.				P.G.		Cheverly		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		5379 Quincy St. # 2 28785			
14. FATHER'S NAME						15. MOTHER'S MAIDEN NAME							
FIRST MIDDLE LAST Frederick C. Burroughs						FIRST MIDDLE LAST Mary Agnes Dent							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)				16b. SOCIAL SECURITY NO.		17. INFORMANT							
No				577-26-9860		8623 Glen Arden Pkwy. Hattie Burroughs- Glen Arden, Md.							
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-pulmonary Arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <u>massive cerebral bleed.</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (the hospital) attended the deceased from <u>6-9</u> 19 <u>87</u> to <u>6-11</u> 19 <u>87</u> that (I) (we) lost saw the deceased alive on <u>6-11</u> 19 <u>87</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.													
22b. SIGNATURE <u>E.H. Burnside MD</u>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED <u>6-12-87</u>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>E.H. Burnside MD</u>				22e. ADDRESS <u>P.G. Hospital Cheverly MD</u>									
23a. BURIAL CREMATION, REMOVAL (SPEEFT)				23b. DATE <u>6/15/87</u>		23c. NAME OF CEMETERY OR CREMATORY <u>HARMONY MCH. PK.</u>				23d. LOCATION CITY OR TOWN COUNTY STATE <u>CANADOVER, P.G., MD.</u>			
24. FUNERAL DIRECTOR NAME <u>H. S. WASHINGTON + SONS</u>				ADDRESS <u>4925 BURROUGHS AVE. N.E.</u>				25a. DATE REC'D. BY REGISTRAR <u>JUN 18 1987</u>				25b. REGISTRAR'S SIGNATURE <u>Julia Sanders-Landree</u>	

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR 11m6629 Item 2a, 2c, 5jt
1- STATE REGISTRAR 7/6/87

1. DECEASED NAME (TYPE OR PRINT)			FIRST MARY			MIDDLE ANN			LAST BURTON			2a. DATE KNOWN OF DEATH MONTH DAY YEAR 6-17 19 87		2b. HOUR M 18
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Feb. 18 1962	6. AGE (IN YEARS) MONTHS DAYS HOURS MIN 25	IF UNDER 1 YR.	IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 6-17 19 87		7d. HOUR M 4:50P		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, DC		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker				12b. KIND OF BUSINESS OR INDUSTRY own home				
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Prince George's County Hospital				12c. USUAL RESIDENCE (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker				12d. KIND OF BUSINESS OR INDUSTRY own home				
13a. STATE Maryland		13b. COUNTY Pr. Georges		13c. CITY OR TOWN Bladensburg		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 5531 Volta Ave., 20710						
14. FATHER'S NAME Richard L. Chauncey			15. MOTHER'S MAIDEN NAME Margaret A. Chauncey											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) N/A		16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) 215-50-3883		17. INFORMANT (father) Richard L. Chauncey				ADDRESS 811 Cannon Rd. Silver Spr. Md. 20904						

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Multiple injuries


Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:

DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY MONTH DAY YEAR 8:55PM 6-16-87		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) precipitated from a building	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) rear of parking garage		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 3401 32nd Ave. Bladensburg, Maryland	
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> .					

ACTUAL SIGNATURE 
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.
TITLE (SPECIFY) M.D. Deputy Chief
DATE SIGNED 6-19-87
ADDRESS 111 Penn St., Balto., MD 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6-22-1987		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven		23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring Montgomery Md.	
24. FUNERAL HOME NAME ADDRESS Finelli's Funeral Home 11800 N.H. Ave., S.S. Md. 20904				25a. DATE REC'D. BY REGISTRAR JUN 29 1987		25b. REGISTRAR Julia Tindon Radabaugh	

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 1. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

CHIEFMAN BOND

20% COTTON FIBER

Handwritten signature

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 7 1 7 9 7 8

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST GERALDINE NALL CALLAHAN			2a. DATE OF DEATH MONTH DAY YEAR 06-13-87		2b. HOUR 4:40AM
3 SEX Female	4 RACE White	5 DATE OF BIRTH MONTH DAY YEAR Feb. 19, 1936		6 AGE (IN YEARS (LAST BIRTHDAY)) 51 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina	7b. CITIZEN OF WHAT COUNTRY? U./S./A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S MD.	
10 CITY OR TOWN OF DEATH CHEVERLY	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE'S HOSPITAL CENTER		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Cafeteria Worker		12b. KIND OF BUSINESS OR INDUSTRY County Government
13a. STATE Maryland		13b. COUNTY Pr. Geo's	13c. CITY OR TOWN Upper Marlboro	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST Samuel Wallace		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma Louise Minor		13e. STREET ADDRESS / ZIP CODE 10612 Kaine Place/ 20772	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. ---		17 INFORMANT ADDRESS James D. Callahan-Marlboro, Md. 20772	
18 CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiopulmonary arrest</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) <i>Acute myocardial infarction</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Coronary artery disease</i>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>Hypertension</i>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>6/12</i> , 19 <i>87</i> , to <i>6/12</i> , 19 <i>87</i> , that (I) (we) last saw the deceased alive on <i>6/12</i> , 19 <i>87</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (will) (did) not view the body after death.					
22b. SIGNATURE <i>Glenn R. Turcotte</i>		DEGREE M.D.		22c. DATED SIGNED 6/13/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Glenn R. Turcotte		22e. ADDRESS 9450 Penn. Ave. #18 Upper Marlboro MD 20772			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 6/16/87	23c. NAME OF CEMETERY OR CREMATORY Lakeview Memorial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Greensboro, North Carolina	
24. FUNERAL DIRECTOR Richard A. Coleman -Upper Marlboro, Md. 20772 Funeral Home		25a. DATE REC'D. BY REGISTRAR JUN 22 1987		25b. REGISTRAR'S SIGNATURE <i>John Anderson-Roadside</i>	



056304 JUN

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be called at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				87 17979 REG. NO.							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MOSHE JOSEPH CARMEL				2a. DATE OF DEATH MONTH DAY YEAR JUNE 7 1987				2b. HOUR 1:40 P			
3. SEX male		4. RACE wh.		5. DATE OF BIRTH MONTH DAY YEAR 7 15 41		6. AGE (IN YEARS LAST BIRTHDAY) 45 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS 0 0		8. IF UNDER 72 HRS HOURS MIN. 0 0	
9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) ISRAEL		9b. CITIZEN OF WHAT COUNTRY? ISRAEL		10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES MD.					
12. CITY OR TOWN OF DEATH LAUREL		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 13803 Briarwood Drive				14a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ELECTRICIAN		14b. KIND OF BUSINESS OR INDUSTRY Private Ind.			
15a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 15a. STATE MD		15b. COUNTY PR. GEO		15c. CITY OR TOWN LAUREL		15d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		15e. STREET ADDRESS / ZIP CODE 13803 BRIARWOOD DRIVE 20708			
16. FATHER'S NAME FIRST MIDDLE LAST ZVI WEINBERGER		17. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ZIPPORAH FOX				18. INFORMANT ADDRESS See # 13 above					
19a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NA		19b. SOCIAL SECURITY NO. 215-44-3155		20. WIFE - Angela CARMEL							
21. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac / Respiratory Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Terminal Stage of Metastatic Cancer DUE TO, OR AS A CONSEQUENCE OF (c) from Colon Cancer											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
21a. DATE OF OPERATION				21b. CONDITION FOR WHICH OPERATION WAS PERFORMED				21c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
22a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) P.M. 19				22b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				22c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 2 OR PART 1)			
23a. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				23b. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)				23c. LOCATION CITY OR TOWN COUNTY STATE Adelphi, Pr. Georges, Md.			
24. I certify that (I) (this XXXX attended the deceased from June 6 1987 to June 6 1987 , that (I) (he) lost saw the deceased alive on June 6 1987 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.											
25a. SIGNATURE J. S. Ch. M.D.				25b. DEGREE M.D.				25c. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		25d. DATE SIGNED 6/7/87	
26a. PHYSICIAN'S NAME (TYPE OR PRINT) 14333 Laurel Bowie Rd. Laurel, Md. 20708				26b. ADDRESS 14333 Laurel Bowie Rd. Laurel, Md. 20708							
27a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				27b. DATE June 9, 1987		27c. NAME OF CEMETERY OR CREMATORY Mt. Lebanon Cemetery		27d. LOCATION CITY OR TOWN COUNTY STATE Adelphi, Pr. Georges, Md.			
28. FUNERAL DIRECTOR NAME Ives-Pearson F.H. Falls Church, Va 22046						28a. DATE REC'D. BY REGISTRAR JUN 10 1987		28b. REGISTRAR'S SIGNATURE Davidson-Radach			

14253
Dear Sir

059224 JUL

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 17980

EOR
STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) Ruth Carr			2a DATE KNOWN OF DEATH <input type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/> HOUR		
3 SEX Female	4 RACE Black	5 DATE OF BIRTH MONTH <input type="checkbox"/> YEAR <input type="checkbox"/> DAY <input type="checkbox"/> MIN.	6 AGE (IN YEARS) LAST BIRTHDAY 57 YRS.	IF UNDER 1 YR. MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/> HOURS <input type="checkbox"/> MIN.	2b DATE PRONOUNCED DEAD 6-18-87
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10 CITY OR TOWN OF DEATH Cheverly		11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Princ George Gen. Hosp.		9 BALTIMORE CITY OR COUNTY OF DEATH Prince George's Co. MD	
13a STATE Maryland		13b COUNTY P.G.		13c CITY OR TOWN Capitol, Hght.	
14 FATHER'S NAME FIRST Liston MIDDLE Mathews LAST Evelyn		15 MOTHER'S MAIDEN NAME FIRST Evelyn MIDDLE Miller LAST Miller		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housekeeper	
12b KIND OF BUSINESS OR INDUSTRY Hotel		13d INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e STREET ADDRESS 608 Suffolk Ave.	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b SOCIAL SECURITY NO. 241-44-5736		17 INFORMANT Berry Carr	
17 ADDRESS 608 Suffolk Ave.					

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE **Probable Atherosclerotic Cardiovascular Disease**
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f LOCATION STREET CITY OR TOWN COUNTY STATE	

22a I certify that I took charge of the remains described above, held on death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐.
Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion

ACTUAL SIGNATURE **August P. Bouquay** TITLE (SPECIFY) **MD** MEDICAL EXAMINER
EXAMINER'S NAME (TYPE OR PRINT) **August P. Bouquay MD 809 Bayburn CR Cpt Md** DATE SIGNED **6-19-87**

23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b DATE 6/24/87	23c NAME OF CEMETERY OR CREMATORY Boney Cemetery	23d LOCATION CITY OR TOWN Saresta, COUNTY North Carolina STATE
24 FUNERAL DIRECTOR NAME R.N. Horton ADDRESS 600 Kennedy St. N.W. Washington, D.C. 20011		25a. DATE REC'D. BY REGISTRAR JUL 8 1987	25b. REGISTRAR'S SIGNATURE Julia Denton-Rodriguez

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING TO THE WORD "PENDING". IN PENCIL IN ITEM 18, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORMS 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL. TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED. WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84 BP
25MA
DHMH - 17
(VR A15 ME (5))

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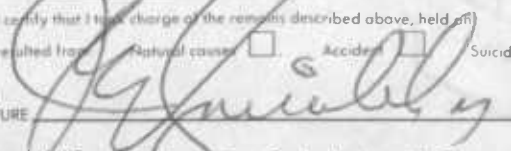

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 7981

1- FOR
STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST VINCENT CARTLEDGE			2a. DATE KNOWN OF DEATH MONTH DAY YEAR EST. MATED 6-13-87 19		2b. HOUR M 6:30A
3 SEX MALE	4 RACE BLACK	5. DATE OF BIRTH MONTH DAY YEAR 9-4-82	6. AGE (IN YEARS) LAST BIRTHDAY 24 YRS.	IF UNDER 1 YR MONTHS DAYS HOURS MIN	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 6-13-87 19
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASH. D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD
10. CITY OR TOWN OF DEATH Capitol Hgts.		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 5619 Coolegge Street		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) NONE	12b. KIND OF BUSINESS OR INDUSTRY NONE
13a. STATE MD		13b. COUNTY P.G.	13c. CITY OR TOWN Cap. Hts	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST JONATHAN CARTLEDGE			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LELA GILCHRIST		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. UNKNOWN		17. INFORMANT Lela Cartledge 5710 Davey ST, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Narcotic (heroin, cocaine) intoxication</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. a <u>alcohol intoxication</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? P.M. 6-12-87		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) subject used drugs	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 5619 Coolegge Street Capitol Hgts., Md.	
22. I certify that I took charge of the remains described above, held (a) Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> .					
ACTUAL SIGNATURE 		TITLE (SPECIFY) M.D. Chief		MEDICAL EXAMINER DATE SIGNED 6-13-87	
EXAMINER'S NAME (TYPE OR PRINT) John E. Smialek, M.D.		ADDRESS 111 Penn Street			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 6/20/87	23c. NAME OF CEMETERY OR CREMATORY Harmony Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Landover PGC MD
24. FUNERAL DIRECTOR NAME MODERN FUNERAL HOME		ADDRESS 3821 14th ST N.W.		25. DATE REC'D. BY REGISTRAR JUN 23 1987	25b. REGISTRAR'S SIGNATURE 

07-84
25M

BP

DHMH - 17
(VR A15 ME (5))

20% COTTON FIBER

CHIEF MAN POWD



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 12 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical certificate filed.

Item #630 per FH 8-11-87 SB

FOR Film #629, Item #4,7a,
1- STATE 15 & 17, 7/13/87, sjb
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

87 17982

1. DECEASED NAME (TYPE OR PRINT) FIRST: <u>ANDRE</u> MIDDLE: <u>-</u> LAST: <u>CASIMIR</u>			2a. DATE OF DEATH MONTH: <u>6</u> DAY: <u>13</u> YEAR: <u>87</u>		2b. HOUR <u>7:30</u> AM		
3. SEX <u>Male</u>		4. RACE <u>Black</u> <u>Hispanic</u>		5. DATE OF BIRTH MONTH: <u>Dec.</u> DAY: <u>15</u> YEAR: <u>1912</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>74</u> YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Haiti</u> <u>Honduras</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Prince Georges County MD.</u>	
10. CITY OR TOWN OF DEATH <u>Beltsville</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>11310 Evans Trail # 104</u>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Cabinet Maker</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>Manufacturing</u>	
13a. STATE <u>Maryland</u>		13b. COUNTY <u>P.G. Co.</u>		13c. CITY OR TOWN <u>Beltsville</u>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST: <u>Dorvil</u> MIDDLE: <u>-</u> LAST: <u>Casimir</u>		15. MOTHER'S MAIDEN NAME FIRST: <u>Louisa</u> MIDDLE: <u>-</u> LAST: <u>Louis</u>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u>		16b. SOCIAL SECURITY NO. <u>067-46-6371</u>	
17. INFORMANT <u>Teilde</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HEART FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: <u>CEREBROVASCULAR ACCIDENTS</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>SEPSIS 2° DEOUBITUS</u>		19. ADDRESS <u>17630 Shady Spring Terr. Gaithersburg, Md.</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>HOURS</u> <u>MONTHS</u> <u>WEEKS</u>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <u>19</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE, FARM, ETC.)		21f. LOCATION STREET: CITY OR TOWN: COUNTY: STATE:			
22a. I certify that (I) (this hospital) attended the deceased from <u>6/10</u> 19 <u>87</u> to <u>6/10</u> 19 <u>87</u> that (I) (we) lost <u>6/10</u> 19 <u>87</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) will (and) (and) not view the body after death.							
22b. SIGNATURE <u>Michael Koch M.D.</u>		DEGREE <u>M.D.</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		DATE SIGNED <u>6/13/87</u>	
22c. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Michael Koch M.D.</u>		22d. ADDRESS <u>9715 MODICAL CRT DR.</u> <u>ROCKVILLE, MD. 20850</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>June/20/87</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		23d. LOCATION CITY OR TOWN: COUNTY: STATE: <u>Rockville, Mont. Co., Md.</u>	
24. FUNERAL DIRECTOR NAME: <u>W. W. Chambers Co., Inc.</u> ADDRESS: <u>Silver Spring, Md.</u>		25a. DATE REC'D. BY REGISTRAR <u>JUN 24 1987</u>		25b. REGISTRAR'S SIGNATURE <u>Julia Gordon-Randall</u>			

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM-1, CERTAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										17983 REG NO							
1. DECEASED NAME (TYPE OR PRINT) FIRST: William MIDDLE: Stephen LAST: Centerfeit										2a. DATE KNOWN OF DEATH ESTIMATED: June 3, 1987		2b. HOUR OF DEATH 5:00 P.M.					
3. SEX M		4. RACE W		5. DATE OF BIRTH MONTH: NOV DAY: 5 YEAR: 53		6. AGE (IN YEARS) LAST BIRTHDAY: 33 YRS.		IF UNDER 1 YR. MONTHS: DAYS: HOURS: MIN.		7c. DATE PRONOUNCED DEAD June 3, 1987		2d. HOUR OF DEATH 5:00 P.M.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland				7b. CITIZEN OF WHAT COUNTRY? United States				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD					
10. CITY OR TOWN OF DEATH Cheverly				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION Prince Georges General Hosp				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) L.S.M. Clerk				12b. KIND OF BUSINESS OR INDUSTRY Post Office					
13a. STATE MD										13b. COUNTY Prince Georges		13c. CITY OR TOWN Cheverly		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 2502 51st Ave 20785	
14. FATHER'S NAME FIRST: William MIDDLE: E. LAST: Centerfeit				15. MOTHER'S MAIDEN NAME FIRST: June MIDDLE: Bennett LAST: Bennett				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes Vietnam				16b. SOCIAL SECURITY NO. 215-58-9514		17. INFORMANT 2508 51st Avenue Cheryl Centerfeit Hyattsville, MD 20781			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxiation</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <u>Hanging</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
										PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 <u>None</u>							
19a. DATE OF OPERATION <u>None</u>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>P.M. 6:30 87</u>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <u>Hung safe</u>									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <u>Home</u>				21f. LOCATION STREET: <u>51st Ave</u> CITY OR TOWN: <u>Cheverly</u> COUNTY: <u>Prince Georges</u> STATE: <u>MD</u>									
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion										22b. TITLE (SPECIFY) M.D. <u>Dep</u>							
ACTUAL SIGNATURE <u>[Signature]</u>				MEDICAL EXAMINER				DATE SIGNED <u>June 3, 1987</u>									
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE June 8, 1987		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d. LOCATION CITY OR TOWN: Brentwood COUNTY: Prince Geo. STATE: MD									
24. FUNERAL DIRECTOR Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Ave. Hyattsville, MD 20781						25a. DATE REC'D. BY REGISTRAR JUN 10 1987		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>									

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1. FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) RODNEY C CHANEY			2a. DATE OF DEATH MONTH DAY YEAR 06-08-87			2b. HOUR 5:42 PM											
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Oct. 3, 1912		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.							
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		10. CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGES MEDICAL CENTER		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Electrician		12b. KIND OF BUSINESS OR INDUSTRY Md. State Roads		13. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD							
14. FATHER'S NAME FIRST MIDDLE LAST Henry E. Chaney			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elsie Wilson Crosby			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b. SOCIAL SECURITY NO. 212-38-2906			17. INFORMANT ADDRESS Annette H. Chaney Same as 13e					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <u>Respiratory Failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <u>Renal Failure Hepatic Failure</u>																	
19a. DATE OF OPERATION 4/2/87			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Bleeding After Surgery</u>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW IN INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>4/2/87</u> , 19 <u>87</u> , to <u>4/8</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>4/8</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE <u>Dr. Boy</u>						DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Sgt. Med. Tech						22e. ADDRESS Chesley Mgmt											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE June 11 1987			23c. NAME OF CEMETERY OR CREMATORY St Barnabas Church Cem.			23d. LOCATION CITY OR TOWN COUNTY STATE Leland, Prince George, Md.								
24. FUNERAL DIRECTOR NAME Beall Funeral Home						25a. DATE REC'D BY REGISTRAR JUN 10 1987			25b. REGISTRAR'S SIGNATURE Benson-Randall								

MEDICAL CERTIFICATION

9

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers, with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

BP

056255

UNITED STATES DEPARTMENT OF JUSTICE

FEDERAL BUREAU OF INVESTIGATION

WASHINGTON, D. C. 20535

TO :

FROM :

SUBJECT :

[Faint, illegible handwritten notes and stamps covering the main body of the document.]

NO

STG-32-1300

WILLIAM H. CUNNINGHAM

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM-3, RETAIN PAGE 4 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1- STATE REGISTRAR Gbj.									
2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR 6-10-87									
2b. HOUR M 9:30P									
3. SEX Female									
4. RACE Black									
5. DATE OF BIRTH 9-18-54									
6. AGE 33 YRS.									
7a. BIRTHPLACE Ethiopia									
7b. CITIZEN OF WHAT COUNTRY? U.S.									
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>									
9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD.									
10. CITY OR TOWN OF DEATH Largo									
11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION 602 Pearse Lane									
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk Economist									
12b. KIND OF BUSINESS OR INDUSTRY Hotel Consult - Ing.									
13a. STATE Maryland									
13b. COUNTY PG									
13c. CITY OR TOWN Largo									
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>									
13. STREET ADDRESS 602 Pearse Lane 20723									
14. FATHER'S NAME W. Belayneh									
15. MOTHER'S MAIDEN NAME T. Ayelech Tessema, Ayelech									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No									
16b. SOCIAL SECURITY NO. 467-46-3622									
17. INFORMANT ADDRESS Sirak Belayneh 2700 Jefferson DR. Alexandria, VA.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple stab wounds DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I a.									
19a. DATE OF OPERATION									
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH									
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? P.M. 6-?-87 19									
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) subject found stabbed									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK									
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home									
21f. LOCATION 602 Pearse Lane Largo, Maryland									
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> .									
ACTUAL SIGNATURE [Signature] TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER									
EXAMINER'S NAME (TYPE OR PRINT) William M. Zane, M.D. ADDRESS 111 Penn Street									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial									
23b. DATE 6-13-87									
23c. NAME OF CEMETERY OR CREMATORY Lincoln									
23d. LOCATION Suitland PG, MD.									
24. FUNERAL DIRECTOR NAME Stonewall Stewart									
24b. ADDRESS D.C. 1425 Maaryland Ave.									
25a. DATE REC'D. BY REGISTRAR JUN 25 1987									
25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in accordance with the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health department within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner is the official cause of death.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR		2a DECEASED NAME William J. Chilcoat, Jr.				2b DATE OF DEATH 6/24/87		2c HOUR 2:30 PM	
3 SEX Male		4 RACE white		5 DATE OF BIRTH 9/21/1912		6 AGE 74		7b HOUR 2:30 PM	
7a BIRTHPLACE Maryland		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Prince George County MD.			
10 CITY OR TOWN OF DEATH Laurel		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Laurel Beltsville Hospital				12a USUAL OCCUPATION plumber		12b KIND OF BUSINESS OR INDUSTRY private	
13a STATE MD		13b COUNTY Prince George		13c CITY OR TOWN Beltsville		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 4715 Prince George Ave. 20705	
FATHER'S NAME William J.		MOTHER'S MAIDEN NAME Maudie Gladden							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) Yes		16b SOCIAL SECURITY NO. WWII 577-07-7000		17 INFORMANT ADDRESS Catherine J. Chilcoat same as #13					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2:00 pm	
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									
DUE TO, OR AS A CONSEQUENCE OF									
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) BAPAL CELL CA, DEMENTIA, NORMAL PRESSURE HYDROPHALUS.									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY 6/12/87 1983		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d INJURY OCCURRED PRESENT			
21a INJURY OCCURRED WHILE AT WORK		21b PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21c LOCATION STREET		CITY OR TOWN LAUREL		STATE MD	
22a I certify that (I) (this hospital) attended the deceased from 6/12/87 to 6/24/87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE Luis A. Capas MD				DEGREE MD				22c DATE SIGNED 6/24/87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) Luis A. Capas MD				22e ADDRESS 8317 CHERRY LA LAUREL MD 20707					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 6/27/87		23c NAME OF CEMETERY OR CREMATORY Ft. Lincoln		23d LOCATION Brentwood Prince George Md			
24a FUNERAL DIRECTOR'S NAME Donald V. Borgwardt				24b ADDRESS 4400 Powder Mill Rd. Beltsville Md 20705		25a DATE REC'D. BY REGISTRAR 6-26-87		25b REGISTRAR'S SIGNATURE	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8717981

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
ELLA J. CHITTAM		06 13 87		1:10AM	
3 SEX	4 RACE	5. DATE OF BIRTH	6 AGE (IN YEARS (LAST BIRTHDAY))	IF UNDER 1 YEAR	
Female	Black	Apr. 25, 1907	80 YRS	IF UNDER 24 HRS	
7a BIRTHPLACE (COUNTRY)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH		
Bowie, Maryland	USA	WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	PRINCE GEORGE'S COUNTY MD.		
10 CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b KIND OF BUSINESS OR INDUSTRY		
CHEVERLY	PRINCE GEORGE'S HOSPITAL CENTER	Housewife			
13a STATE	13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS?	13e STREET ADDRESS / ZIP CODE	
Maryland	P.G.	Bowie	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	12705 Duckett Town Rd 20715	
14 FATHER'S NAME		15. MOTHER'S MAIDEN NAME			
Truman Duckett		Mattie Glasco			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO.		17 INFORMANT ADDRESS	
no		578 28 6480		Mary Brown-niece-13222 11th Street,	
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the colon</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 years</u>					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from <u>6/12</u> 19 <u>87</u> to <u>6/13</u> 19 <u>87</u> that (I) (we) last saw the deceased alive on <u>6/12</u> 19 <u>87</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) did not view the body after death.		22b SIGNATURE		22c DATE SIGNED	
		<u>Nelson G. Goodman</u>		6/14/87	
22d PHYSICIAN'S NAME (TYPE OR PRINT)		22e ADDRESS			
NELSON G. GOODMAN		3231 SUPERIOR LANE Bowie			
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE		23c NAME OF CEMETERY OR CREMATORY	
Burial		June 19, 1987		Fort Lincoln Cemetery Brentwood, Maryland	
24 FUNERAL DIRECTOR'S NAME		25a DATE REC'D. BY REGISTRAR		25b REGISTRAR'S SIGNATURE	
Stewart Funeral Home-4001 Benning Road, N.E.		JUL 24 1987		<u>Julia B. ...</u>	

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF AVAILABLE, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FOR PAGES 1, 2, AND 3. START PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17988
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST <i>Harvey</i> MIDDLE <i>S</i> LAST <i>Chown</i>			2a. DATE KNOWN OF DEATH MONTH <input checked="" type="checkbox"/> DAY <input checked="" type="checkbox"/> YEAR <i>1987</i>			2b. HOUR M <i>8</i>					
3. SEX <i>Male</i>	4. RACE <i>White</i>	5. DATE OF BIRTH MONTH <i>04</i> DAY <i>09</i> YEAR <i>1912</i>	6. AGE (IN YEARS) LAST BIRTHDAY <i>75</i> YRS.	IF UNDER 1 YR. MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>	IF UNDER 24 HRS. HOURS <input type="checkbox"/> MIN. <input type="checkbox"/>	2c. DATE PRONOUNCED DEAD MONTH <i>6-8</i> DAY <i>19</i> YEAR <i>87</i>			2d. HOUR M <i>339</i>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Virginia</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Prince George's County</i> MD					
10. CITY OR TOWN OF DEATH <i>Lanham</i>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Doctor's Hospital of P.G. County</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Musician</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Self Employed</i>			
13a. STATE <i>Maryland</i>			13b. COUNTY <i>P.G.</i>		13c. CITY OR TOWN <i>Lanham</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS <i>9123 6th Street 20706</i>	
14. FATHER'S NAME FIRST <i>Harvey</i> MIDDLE <i></i> LAST <i>Chown</i>				15. MOTHER'S MAIDEN NAME FIRST <i>Vivian</i> MIDDLE <i></i> LAST <i>Chase</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>Yes-Army</i>			(IF YES, GIVE WAR OR DATES) <i>W.W.II</i>		16b. SOCIAL SECURITY NO. <i>579-03-5095</i>		17. INFORMANT (Wife) <i>1010 Locust Court</i> <i>Annette R. Chown Owens, Maryland 20736</i>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Squamous cell carcinoma of the lung</i> (b) <i></i> (c) <i></i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last <i></i>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i></i>		
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I <i>Emphysema</i>											
19a. DATE OF OPERATION <i></i>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <i></i>						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <i></i>			21f. LOCATION STREET <i></i> CITY OR TOWN <i></i> COUNTY <i></i> STATE <i></i>					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>Augusta J. Pringle</i>			TITLE (SPECIFY) <i>Deputy</i>			MEDICAL EXAMINER			DATE SIGNED <i>6-8-87</i>		
EXAMINER'S NAME (TYPE OR PRINT) <i>Augusta J. Pringle MD</i>			ADDRESS <i>5009</i>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>			23b. DATE <i>06/11/87</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Parklawn Cemetery</i>			23d. LOCATION CITY OR TOWN <i>Rockville</i> COUNTY <i>Montgomery</i> STATE <i>Maryland</i>			
24. FUNERAL DIRECTOR <i>Francis Gasch's Sons Funeral Home, P.A.</i>						25a. DATE REC'D. BY REGISTRAR <i>JUN 12 1987</i>		25b. REGISTRAR'S SIGNATURE <i></i>			
4739 Baltimore Avenue Hyattsville, Md. 20781											

07/84
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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 17989

1- FOR STATE REGISTRAR			2a DATE KNOWN OF DEATH			2b HOUR		
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Charlie Lee Edward Coleman Sr.			2c DATE PRONOUNCED DEAD			2d HOUR		
3 SEX Male			4 RACE Black			5 DATE OF BIRTH MONTH DAY YEAR May 27, 1931		
6 AGE (IN YEARS) (LAST BIRTHDAY) YRS. 56			IF UNDER 1 YR MONTHS DAYS			IF UNDER 24 HRS HOURS MIN.		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia			7b CITIZEN OF WHAT COUNTRY? U.S.A.			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
9 BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD.			10 CITY OR TOWN OF DEATH Clinton			11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION 7916 Denton Drive		
12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Air Force			12b KIND OF BUSINESS OR INDUSTRY U.S. Govt.			13a STATE Maryland		
13b CITY OR TOWN P. G.			13c CITY OR TOWN Clinton			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e STREET ADDRESS 7916 Denton Drive			13f ZIP CODE 20735			14 FATHER'S NAME FIRST MIDDLE LAST Linwood Coleman		
15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jessie Ross			16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES 1955-1975			16b SOCIAL SECURITY NO. 231-36-2262		
17 INFORMANT ADDRESS Doris E. Coleman Same as 13 A-E			18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ethanol abuse</u> DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a. <u>Diabetic, Hypertensive cardiovascular disease, grand</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)		
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion			22b DATE 06/22/87			22c NAME OF CEMETERY OR CREMATORY Arlington Natl Cem.		
22d LOCATION CITY OR TOWN COUNTY STATE Arlington Arlington VA.			22e DATE REC'D. BY REGISTRAR JUN 24 1987			22f REGISTRAR'S SIGNATURE Julia Davidson-Rodgers		
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b DATE 06/22/87			23c NAME OF CEMETERY OR CREMATORY Arlington Natl Cem.		
23d LOCATION CITY OR TOWN COUNTY STATE Arlington Arlington VA.			23e DATE REC'D. BY REGISTRAR JUN 24 1987			23f REGISTRAR'S SIGNATURE Julia Davidson-Rodgers		
24 FUNERAL DIRECTOR NAME Lee Funeral Home, Inc.			24b ADDRESS 6633 Old Alexander Ferry Rd. Clinton, Md 20735			24c DATE REC'D. BY REGISTRAR JUN 24 1987		
24d REGISTRAR'S SIGNATURE Julia Davidson-Rodgers			24e DATE REC'D. BY REGISTRAR JUN 24 1987			24f REGISTRAR'S SIGNATURE Julia Davidson-Rodgers		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body. **IMPORTANT:** If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8717990
REG. NO.

1 FOR STATE REGISTRAR		2a DATE OF DEATH MONTH DAY YEAR		2b HOUR	
1 DECEASED NAME (TYPE OR PRINT)		3 SEX		4 RACE	
FIRST MIDDLE LAST		MALE		Black	
RALPH COLEMAN		5 DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)	
		12 19 07		79	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
Washington, D.C.		U.S.A.		9 BALTIMORE CITY OR COUNTY OF DEATH	
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
TAKOMA PARK		W A H		Unemployed	
13a STATE		13b CITY OR TOWN		13c STREET ADDRESS / ZIP CODE	
Wash., D.C.		Wash., D.C.		#9 - 47th St., S.E. 20019	
14 FATHER'S NAME FIRST MIDDLE LAST		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)	
John Coleman		Daisy Dawson		No	
16b SOCIAL SECURITY NO.		17 INFORMANT ADDRESS		18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1 DEATH WAS CAUSED BY:	
578-12-9831		Annabelle Mance (sister) Wash., D.C. 20010		IMMEDIATE CAUSE (a) <u>Cancer of esophagus & colon</u>	
				DUE TO, OR AS A CONSEQUENCE OF (b)	
				DUE TO, OR AS A CONSEQUENCE OF (c)	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from 6/23 1987, to 6/23 1987, that (I) (we) last saw the deceased alive on 6/23 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.		22b SIGNATURE DEGREE		22c DATE SIGNED	
Fumikazu Kawakami M.D.		1150 VARNUMS AVE. WASH. D.C. 20019		6/28/87	
22d PHYSICIAN'S NAME (TYPE OR PRINT)		22e ADDRESS		23a BURIAL, CREMATION, REMOVAL	
Fumikazu Kawakami M.D.		1150 VARNUMS AVE. WASH. D.C. 20019		Burial	
23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION CITY OR TOWN COUNTY STATE	
6-30-87		Harmony Memorial Park		Landover, Md.	
24 FUNERAL DIRECTOR NAME ADDRESS		25a DATE REC'D. BY REGISTRAR		25b REGISTRAR'S SIGNATURE	
Vann & Williams, 4804 Ga. Ave., N.W., Wash., D.C.		JUL 07 1987		John Dawson-Landover	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified for autopsy.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 17991
REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
7. DECEASED NAME (TYPE OR PRINT)		3. SEX		4. RACE	
Marcel H. Courtillet		Male		Caucasian	
5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	
09/26/26		60		France	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		10. CITY OR TOWN OF DEATH	
		Prince George's		Camp Springs	
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
5511 Auth Rd		Attache'		French Govt. Re	
13a. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13b. STREET ADDRESS / ZIP CODE		13c. COUNTY	
		5511 Auth Rd 20746		P. G.	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16. SOCIAL SECURITY NO.	
Marius Courtillet		Germaine Jacquet		None	
17. INFORMANT		18. CAUSE OF DEATH		19. DATE OF OPERATION	
Alice Courtillet Same as 13 A-E		PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>motor vehicle accident</u>		19a. CONDITION FOR WHICH OPERATION WAS PERFORMED	
		DUE TO, OR AS A CONSEQUENCE OF (b) <u>motor vehicle accident</u>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
		DUE TO, OR AS A CONSEQUENCE OF (c) <u>motor vehicle accident</u>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
		PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 <u>hypertension, diabetes</u>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED	
		10/6 19 7		ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2	
		21d. INJURY OCCURRED		21e. PLACE OF INJURY	
		WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
		21f. LOCATION		21g. LOCATION	
		STREET		CITY OR TOWN	
		10/6		Clinton	
		22a. I certify that (I) this hospital attended the deceased from 10/6 19 7, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) did not view the body after death.		22b. SIGNATURE	
				DEGREE	
				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
				22c. DATE SIGNED	
				6/5/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		23a. BURIAL, CREMATION, REMOVAL	
Dr. Lewis H. Dennis		831 University Blvd. East Suit 35 Sil. Spg Md.		Burial	
23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
06/08/87		Resurrection Cemetery		Clinton Prince George's MD	
24. FUNERAL DIRECTOR		25a. DATE REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Lee Funeral Home, Inc.		JUN 16 1987		John E. R. R. R.	
NAME		ADDRESS			
6633 Old Alexander Ferry Rd Clinton, Md 20735					

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print) OTHO Clarence Curry			2a. DATE OF DEATH Month 6 Day 12 Year 1987		2b. HOUR M
3. SEX Male	4. RACE Afro American	5. DATE OF BIRTH 13 Apr. 1897		6. AGE (in years last birthday) 90	IF UNDER 1 YEAR MONTHS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Virginia	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9. COUNTY OF DEATH Prince George Md.		
10. CITY OR TOWN OF DEATH Landoner Md.	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 1204 Elsg Ave		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Engineer	12b. KIND OF BUSINESS OR INDUSTRY Apt. Rental	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.	13b. COUNTY Prince Geo.	13c. CITY OR TOWN Landoner	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 1204 Elsg Ave	
14. FATHER'S NAME First Middle Last Unknown		15. MOTHER'S MAIDEN NAME First Middle Last Mattie Curry			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO. 578-10-7381		17. INFORMANT Otho Curry Jr. 1204 Elsg Ave Landoner Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metabolic Acidosis DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) malnutrition-Decubitus Ulcers DUE TO, OR AS A CONSEQUENCE OF (c) Generalized Atherosclerosis					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week 2 month 2 years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) Senility					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, natly medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from 2-15 , 19 86 , to 26 May , 19 87 , that (I) (we) last saw the deceased alive on 26 May 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Thomas M. Hultine MD			ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22c. DATE SIGNED 6-12-87	
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 17 Jun '87	23c. NAME OF CEMETERY OR CREMATORY Harmony Mem.	23d. LOCATION (City or Town) (County) (State) Landoner P.C. Md.		
24. FUNERAL DIRECTOR S. Stepant 561		ADDRESS 1425 Md. Ave N.E.		25a. RECEIVED BY REGISTRAR DATE JUN 25 1987	25b. REGISTRAR'S SIGNATURE Julia D. Brown-Randall

Blank lined paper with two binder holes on the left.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 17993

1- FOR STATE REGISTRAR		REG. NO.	
1 DECEASED NAME (TYPE OR PRINT)		2a DATE OF DEATH MONTH DAY YEAR	
William Smith Dare Jr.		June 29, 1987	
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (IN YEARS LAST BIRTHDAY)
Male	Caucasian	Nov. 8, 1916	70
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH
Washington, D.C.	U.S.A.		Prince Georges MD
10 CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b KIND OF BUSINESS OR INDUSTRY
Clinton	9602 Michael Drive	Specialist-Ret.	Fed. Gov't.
13a STATE	13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS?
Maryland	Pr. Georges	Clinton	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14 FATHER'S NAME FIRST MIDDLE LAST	15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST	13e STREET ADDRESS / ZIP CODE	
William S. Dare Sr.	Edna W. Balderston	9602 Michael Drive 20735	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES)	17 INFORMANT	ADDRESS
Yes	WW II	Gladys K. Dare	Same as #13 a-e.
18 CAUSE OF DEATH Enter only one cause per line for a, b, and c. PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last b) <u>Chronic Bronchitis and Emphysema</u> DUE TO, OR AS A CONSEQUENCE OF c) <u>Minutes</u> <u>Years</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <u>Degenerative Joint Disease</u>			
19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NO WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)	21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (1) <u>Hospital</u> attended the deceased from <u>June 28, 1987</u> to <u>6/29, 1987</u> that (2) <u>last</u> saw the deceased alive on <u>June 28, 1987</u> and that in my <u>own</u> opinion death occurred on the date and hour and from the causes stated above; (3) <u>last</u> did not view the body after death.			
22b SIGNATURE <u>[Signature]</u>	DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c DATE SIGNED June 30, 1987	
22d PHYSICIAN'S NAME (TYPE OR PRINT)	22e ADDRESS		
Louis V. Kaufman	8926 Woodyard Road Clinton, Maryland		
23a BURIAL, CREMATION, REMOVAL (SPECIFY)	23b DATE	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION CITY OR TOWN COUNTY STATE
Burial	July 1, 1987	Cedar Hill Cemetery	Suitland Pr. Georges Md.
24 FUNERAL DIRECTOR NAME		25a DATE REC'D. BY REGISTRAR	25b REGISTRAR'S SIGNATURE
Lee Funeral Home, Inc. 6633 Old Alexander Ferry Rd Clinton, Md.		JUL 01 1987	



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove and forward to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition. If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical information is important.

FOR
1- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87

REG NO

17994

1 DECEASED NAME (TYPE OR PRINT) LONA Delores DAVIDSON			2a DATE OF DEATH MONTH DAY YEAR 6-20-87		2b HOUR 11:25 PM	
3 SEX FEMALE		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR 4 29 09		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington (State)		7b CITIZEN OF WHAT COUNTRY? U.S.A.		6 AGE (IN YEARS LAST BIRTHDAY) 78		
10 CITY OR TOWN OF DEATH RIVERDALE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) LELAND MEMORIAL HOSPITAL		9 BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE CO. MD		
12a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Maryland		13b COUNTY P.G.		13c CITY OR TOWN Riverdale		
14 FATHER'S NAME FIRST MIDDLE LAST Henry Budding		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Donna Doolittle		12b USUAL OCCUPATION (TYPE OF WORK FOR MEET OF WORKING LIFE) Housewife		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) No		16b SOCIAL SECURITY NO 229-22-3356		17 INFORMANT Robert Davidson (Son) Churchton, Md. 20733		
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Stroke - Basal ganglia bleeding DUE TO, OR AS A CONSEQUENCE OF (b) Acute urinary tract infection Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last Hypertension DUE TO, OR AS A CONSEQUENCE OF (c) Hypertension						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a						
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE		
22a I certify that (I) (this hospital) attended the deceased from 5/19/87 to 6/20/87 , that (I) (we) lost sight of the deceased during 6/20/87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) last observed the body after death.						
22b SIGNATURE [Signature]		DEGREE ATTENDING MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 6/21/87		
22d PHYSICIAN'S NAME (TYPE OR PRINT) ABRAHAM DABELA		22e ADDRESS 4404 Queensbury Rd. Riverdale Md				
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 06/24/87		23c NAME OF CEMETERY OR CREMATORY Arlington National Cem. Arlington Virginia		
24 FUNERAL DIRECTOR Francis Gasch's Sons Funeral Home, P.A.		25a DATE REC'D. BY REGISTRAR JUN 23 1987		25b REGISTRAR'S SIGNATURE [Signature]		
24b ADDRESS 4739 Baltimore Avenue Hyattsville, Md. 20781						



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8717995	
1. FOR STATE REGISTRAR					2a. DATE OF DEATH		MONTH DAY YEAR		7b. HOUR		
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Anita DAVIS					June 4, 1987				5:30P M		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
FEMALE		CAUCASIAN		OCTOBER 2 1926		60 YRS		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
NEW YORK CITY		U.S.A.				PRINCE GEORGE'S MD					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
lanham		doctors' HOSPITAL OF PR. GEO. CO.				HOMEMAKER		HOME			
13a. STATE					13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		
MARYLAND					PRINCE GEORGE		LANHAM		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST						
GEORGE ZWEIG					KATE LEVINE						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)					16b. SOCIAL SECURITY NO.		17. INFORMANT				
NO					054-20-6757		SON NEW CARROLLTON, MD 20784 GARY DAVIS; 6445 FAIRBORN TERRACE				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <u>cardio-respiratory arrest</u>										<u>intermediate</u>	
DUE TO, OR AS A CONSEQUENCE OF (b) <u>metastatic breast cancer</u>										<u>9 years</u>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
				HOUR A.M. MONTH DAY YEAR							
21d. INJURY OCCURRED				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION					
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>						STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>6/2</u> 19 <u>87</u> to <u>6/4</u> 19 <u>87</u> that (I) (we) last saw the deceased alive on <u>6/4</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE				DEGREE				22c. DATE SIGNED			
<u>Dr. Granite</u>								6/5/87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS							
David Granite, MD				115 Centerway Greenbelt, MD							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION			
BURIAL			6/7/87		MT. LEBANON CEMETERY			ADELPHI PRINCE GEORGE MD			
24. FUNERAL DIRECTOR NAME				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE			
DANZANSKY-GOLDBERG MEMORIAL CHAPELS				JUN 10 1987				<u>James R. ...</u>			
1170 ROCKVILLE PIKE, ROCKVILLE, MD 20852											

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1981 10 17

Page 1

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1981 10 17

[Large, stylized handwritten letters, possibly 'SWA' or 'SWA']

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 17996

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
HERMAN S. DENT		06-17-87		7:05AM	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YEAR	
Male	Black	Jan. 12, 1910	77 YRS	IF UNDER 24 HRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
Md.	U.S.A.		PRINCE GEORGE'S COUNTY MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK AND MOST OF WORKING (IFE)		12b. KIND OF BUSINESS OR INDUSTRY
CHEVERLY	PRINCE GEORGE'S HOSPITAL CENTER		Apt. Custodian		Housekeeping
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?		
Md.	P.G.	Glen Arden	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME		16. STREET ADDRESS / ZIP CODE		
(Unknown)	(Unknown)		8625 Glen Arden Pkwy. 20801		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO.	17. INFORMANT			
No	218-12-9331	9011 Varnum St. Joseph Clayton-Lanham, Md.			
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>CARDIO PULMONARY ARREST</u>					MINUTES
DUE TO, OR AS A CONSEQUENCE OF					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					
(b) <u>SEVERE OBSTRUCTIVE LUNG DISEASE</u>					YEARS
DUE TO, OR AS A CONSEQUENCE OF					
(c) <u>KYPHOSCOLIOSIS AND TOBACCO ABUSE</u>					YEARS
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)					
<u>MALNUTRITION</u>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
	HOUR A.M. MONTH DAY YEAR				
	P.M. 19				
21d. INJURY OCCURRED	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION			
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		CITY OR TOWN COUNTY STATE			
22a. I certify that (1) this hospital attended the deceased from <u>6-10</u> , 19 <u>87</u> , to <u>JUNE 16</u> , 19 <u>87</u> , that (1) (we) lost saw the deceased alive on <u>JUNE 16</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.					
22b. SIGNATURE	DEGREE				22c. DATE SIGNED
<u>George Bone</u>					6-18-87
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS				
<u>GEORGE BONE</u>	<u>8601 MAKING SR. HWY LANHAM 20706</u>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION		
	6/20/87	HARMONY MEH. PARK	LANDOVER, P.G. MD.		
24. FUNERAL DIRECTOR	25a. DATE REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
<u>H.S. WASHINGTON & SONS</u>	JUL 8 1987		<u>Julia D. Smith-Rodgers</u>		

FOR B. H. H.

[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page.]

10-15-1947 [illegible] [illegible] [illegible]

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(continued)

21	10-15-1947	2	10-15-1947
22	10-15-1947	2	10-15-1947
23	10-15-1947	2	10-15-1947
24	10-15-1947	2	10-15-1947
25	10-15-1947	2	10-15-1947
26	10-15-1947	2	10-15-1947
27	10-15-1947	2	10-15-1947
28	10-15-1947	2	10-15-1947
29	10-15-1947	2	10-15-1947
30	10-15-1947	2	10-15-1947

10-15-1947

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 17997
REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	P M
1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST		June		27 1987 10:06
Archibald G DILLON								
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. UNDER 1 YEAR		8. UNDER 24 HRS
Male	caucasian	August 12, 1904		82		MONTHS		DAY
7a. BIRTHPLACE (STATE OR FOREIGN)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		MD.
Virginia		U.S.A.				Prince George's		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Riverdale		Leland Memorial Hospital		Salesman		Car dealership		
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE
Md.		Prince George		Laurel		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		41 Avondale Street 20707
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO		17. INFORMANT ADDRESS
Daniel		Ida		yes		578-09-3371		Leona Whitehead Dillon Same as above
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		Acute pneumonitis with sepsis		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		Two weeks		
DUE TO, OR AS A CONSEQUENCE OF								
Conditions, if any, which gave rise to immediate cause or stating the underlying cause lost		(b)		DUE TO, OR AS A CONSEQUENCE OF		(c)		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1		Renal failure. Congestive heart failure. Non-insulin-dependent diabetes mell.						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from		26 September, 19 71		to 27 June, 19 87		that (I) (we) last saw the deceased alive on 27 June 19 87		
and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.		22b. SIGNATURE		DEGREE		22c. DATE SIGNED		
		Carl J. Houmann				27 June, 1987		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				
Carl J. Houmann, M. D.		4404 Queensbury Rd., Riverdale, MD 20737						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		
Burial		July 1, 1987		Ivy Hill Cemetery		Laurel P.G. Md.		
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Donaldson Funeral Home		Laurel, Md 20707		JUL 06 1987				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

20% COTTON FIBER

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1934

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 7 1-7 9 9 8

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		3. SEX		4. RACE	
FIRST MIDDLE LAST		Male		White	
Conley Hall DILLON		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
Oct. 19 1906		80		IF UNDER 1 YEAR	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
Ohio		USA		9. BALTIMORE CITY OR COUNTY OF DEATH	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OR LOOK FOR MOST OF WORKING LIFE)	
Lanham		Doctors Hospital		Professor	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN	
Maryland		Montgomery		Silver Spring	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	
FIRST MIDDLE LAST		FIRST MIDDLE LAST		16b. SOCIAL SECURITY NO.	
Elmer W. Dillon		Ottie Hall		218-56-9160	
17. INFORMANT		18. CAUSE OF DEATH		19. DATE OF OPERATION	
ADDRESS		Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY		6/15/87	
Virginia B. Dillon -wife-(same as 13e)		IMMEDIATE CAUSE (a) <u>Respiratory failure</u>		SUBSTERNAL GOITER	
		DUE TO, OR AS A CONSEQUENCE OF		20a. AUTOPSY?	
		(b) <u>Adult Respiratory Distress Syndrome</u>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
		DUE TO, OR AS A CONSEQUENCE OF		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
		(c) <u>Pulmonary Emboli</u>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
		PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
		<u>Possible aspiration pneumonia</u>		21b. TIME OF INJURY	
		<u>post subtotal thyroidectomy</u>		HOUR A.M. MONTH DAY YEAR	
		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)		P.M. 19	
		21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
		WHILE AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/>		21f. LOCATION	
		22a. I certify that (I) (this hospital) attended the deceased from		STREET CITY OR TOWN COUNTY STATE	
		saw the deceased alive on <u>June 26</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated		22b. SIGNATURE	
		above, (I) (we) (did) (did not) view the body after death.		DEGREE	
		22c. DATE SIGNED		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL STAFF PHYSICIAN <input type="checkbox"/>	
		6/27/87		22d. PHYSICIAN'S NAME (TYPE OR PRINT)	
		22e. ADDRESS		23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	
		7411 Riggs Road, Hyattsville, Md. 20783		Burial	
		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
		7-1-1987		Rome Cemetery	
		23d. LOCATION		23e. DATE REC'D. BY REGISTRAR	
		Rome Lawrence Ohio		JUN 29 1987	
		23f. REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR	
		Julia Sanders-Randall		Hines/Rinaldi Funeral Home	
				11800 N.H. Ave.	
				Silver Spring, Md.	

BP

UNITED STATES ARMY

NOTICE

100-100000

UNITED STATES ARMY
DEPARTMENT OF THE ARMY
WASHINGTON, D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CHARLIE DIXON					2a. DATE OF DEATH MONTH DAY YEAR 06-16-87				
3 SEX FEMALE		4 RACE BLK		5. DATE OF BIRTH MONTH DAY YEAR JAN 27 1920		6 AGE (IN YEARS LAST BIRTHDAY) 67 YRS		2b HOUR 7:25AM	
7a. BIRTHPLACE (STATE OR FOREIGN) NORTH CAROLINA		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S MD			
10. CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE'S HOSPITAL CENTER				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MD.		13b. COUNTY P. G.		13c. CITY OR TOWN LAUREL		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 14101 ADKINS RD. 20708	
14. FATHER'S NAME FIRST MIDDLE LAST JAMES JARMAN				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MYRTLE WOOTEN					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO				16b. SOCIAL SECURITY NO. NOT STATED		17 INFORMANT ADDRESS ROENIA BALLARD 14101 ADKINS RD.			
18. CAUSE OF DEATH: Enter only one cause per line (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio Pulmonary Arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <u>Chronic Renal Failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AL WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 3-14 19 87, to 6-16 19 87, that (I) (we) last saw the deceased alive on 6/15/87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated there, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>ROG-ERIO V. Villanueva MD</u>					DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 6/16/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS PGA & ME				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE JUNE 20 1987		23c. NAME OF CEMETERY OR CREMATORY FARRIOR CEM.		23d. LOCATION ROSE HILL, COUNTY N. C. STATE		
24. FUNERAL DIRECTOR WATSON F. H. INC. 3435 14th ST., N.W. WASH. D. C.					25a. DATE REC'D BY REGISTRAR JUN 23 1987		25b. REGISTRAR'S SIGNATURE <u>Julia Benson</u>		

MEDICAL CERTIFICATION

UNITED STATES DEPARTMENT OF AGRICULTURE		BUREAU OF PLANT INDUSTRY		PLANT INDUSTRY DIVISION	
OFFICE OF THE CHIEF		PLANT INDUSTRY DIVISION		PLANT INDUSTRY DIVISION	
WASHINGTON, D. C.		WASHINGTON, D. C.		WASHINGTON, D. C.	
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859	860	861	862	863	864
865	866	867	868	869	870
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1099	1100	1101	1102	1103	1104
1105	1106	1107	1108	1109	1110
1111	1112	1113	1114	1115	1116
1117	1118	1119	1120	1121	1122
1123	1124	1125	1126	1127	1128
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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 18000

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) ROBERT ELLSWORTH DIXON			2a. DATE OF DEATH MONTH DAY YEAR June 6, 1987		2b. HOUR 3:00 P.M.				
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR July 2, 1918		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD.			
10. CITY OR TOWN OF DEATH Berwyn Heights		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 6008 Quebec Street		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Radio Mechanic		12b. KIND OF BUSINESS OR INDUSTRY Auto shop			
13a. STATE Maryland		13b. COUNTY Prince Geo.		13c. CITY OR TOWN Berwyn Heights		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET ADDRESS / ZIP CODE 6008 Quebec Street 20740	
14. FATHER'S NAME FIRST MIDDLE LAST William F. Dixon			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Edna M. Poore						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. WW-2		17. INFORMANT Mrs. Augusta E. Dixon, Same as Line #13		ADDRESS			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lung Cancer DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 Years									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 5/15/87 to 6/6/87 that (I) (we) lost saw the deceased alive on 5/15/87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Harvey Kizer		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 6/8/87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Harvey Kizer		22e. ADDRESS 5920 Woodward Rd. Chazy, MD							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE June 9, 1987		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood, P.G., Maryland			
24. FUNERAL DIRECTOR FRANCIS GASCH'S SONS FUNERAL HOME, P.A. 4739 Baltimore Ave., Hyattsville, Maryland				25a. DATE REC'D. BY REGISTRAR JUN 10 1987		25b. REGISTRAR'S SIGNATURE William R. Lander			

055444

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 100. 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE KEPT WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 18001

1- STATE REGISTRAR		DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		7a. DATE KNOWN OF DEATH		MONTH DAY YEAR		HOUR	
		RICHARD CHARLES DOUGLAS				6-2-87		19		87	
1. SEX	4. RACE	5. DATE OF BIRTH	6. AGE	IF UNDER 1 YR.	IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD	MONTH DAY YEAR		HOUR		
Male	White	NOV. 30, 1919	67 YRS.			JUNE 2 19 87	3:10A				
7a. BIRTHPLACE	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH							
Iowa	USA	WIDOWED XX NEVER MARRIED		Prince George's							
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION		12b. KIND OF BUSINESS OR INDUSTRY						
Lanham	Doctors' Hospital of Pr. Geo. Co.		Sales		Computer's						
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
Maryland		Pr. George's		Bowie		YES X NO		3407 Maple Bluff Lane		20715	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
unk.		unk.		YES		WW II		Gerald P. Douglas		146 Monroe St. Apt. 101 Rockville, MD 20850	
18. CAUSE OF DEATH		PART I DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF					
9289				Cardio myopathy							
				(b) Chronic Ethylism							
				(c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a.				Laceration left occipital region, unphysic							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		YES		NO			
21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED							
		HOUR A.M. MONTH DAY YEAR		ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2							
21d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK		21e. PLACE OF INJURY		21f. LOCATION		CITY OR TOWN		COUNTY		STATE	
		STREET, FACTORY, FARM, ETC.		STREET							
22a. I certify that I took charge of the remains described above, held on death resulted from:		Autopsy		Inspection		Inquiry		and in my opinion			
Natural causes		Accident		Suicide		Homicide		Undetermined manner			
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED							
Augusto P. Rodriguez		M.D. Deputy		6-2-87							
EXAMINER'S NAME		ADDRESS									
(TYPE OR PRINT)		Augusto P. Rodriguez, M.D.		5009 Rayburn Ct., Temple Hills, MD							
23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		COUNTY		STATE	
Burial		JUNE 6, 1987		Sacred Heart Church Cem		Bowie, Prince George's,		MD			
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
Beall Funeral Home		Bowie, MD 20715-3043		JUN 3 1987							

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DHMH - 17
(VR A15 ME (5))

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44 OF

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 18002

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Elmer Lewis Dreyer			2a. DATE OF DEATH MONTH DAY YEAR 06-06-87		2b. HOUR 1:10 P.M.		
3 SEX Male		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR December 14, 1900		6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD.	
10. CITY OR TOWN OF DEATH Clinton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Pineview Manor Ext Care Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Steamfitter-Plumber		12b. KIND OF BUSINESS OR INDUSTRY Construction	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Derwood		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST William Dreyer		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sylvene Rieser		13e. STREET ADDRESS / ZIP CODE 6000 Muncaster Mill Road 20855			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 219-03-1630		17. INFORMANT Louis A. Dreyer (Son) Same as #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>ARTERIOSCLEROSIS</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>YEARS</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <u>MULTIPLE DEUBITUS ULCERS</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (u) (his hospital) attended the deceased from <u>5/22</u> , 19 <u>87</u> , to <u>6/6</u> , 19 <u>87</u> that (we) last saw the deceased alive on <u>6/6</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.							
22b. SIGNATURE <u>AW</u>		DEGREE <u>M</u>		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>6/6/87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>PHILIP WISOTSKY M.D.</u>		22e. ADDRESS <u>6188 Oxon Hill Rd. Oxon Hill MD.</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 06/10/87		23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D.C.	
24. FUNERAL DIRECTOR Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Avenue Hyattsville, Md. 20781				25a. DATE RECEIVED BY REGISTRAR JUN 12 1987			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be voluntarily filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in accordance with the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8718003

1. DECEASED NAME (TYPE OR PRINT) James Joseph Duggan			2a. DATE OF DEATH MONTH DAY YEAR June 12, 1987		2b. HOUR 2:30 P.M.
3 SEX Male	4 RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR 3 3 1939		6 AGE (IN YEARS LAST BIRTHDAY) 48 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.	7b. CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD.		
10. CITY OR TOWN OF DEATH Laurel	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (TYPE IN FULL CITY, GIVE STREET ADDRESS) 6005 Parkway Drive		12a. USUAL OCCUPATION (TYPE OF WORK FOR WORK OF WORKING LIFE) Rest. Owner	12b. KIND OF BUSINESS OR INDUSTRY Food	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 3a. STATE Md.		13b. COUNTY P.G.	13c. CITY OR TOWN Laurel	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 6005 Parkway Drive 20707
14. FATHER'S NAME FIRST MIDDLE LAST James Joseph Duggan		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Olga C. Stanton			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1956-1960	17. INFORMANT ADDRESS Mary P. Duggan same as 13e		
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinomatous</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) <u>Squamous Carcinoma Pharynx</u> DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (1) (this hospital) attended the deceased from <u>5/1</u> , 19 <u>87</u> , to <u>6/12</u> , 19 <u>87</u> , that (1) (we) lost saw the deceased alive on <u>6/10</u> , 19 <u>87</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (1) <u>we</u> (did not) view the body after death.					
22b. SIGNATURE <u>Thomas A. MacLean MD</u>		DEGREE		22c. DATE SIGNED <u>6/13/87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Thomas A. MacLean, MD</u>		22e. ADDRESS <u>3450 Ft. Mde. Rd. Laurel, MD</u>			
23a. BURIAL, CREMATION, REMOVAL (Burial)	23b. DATE <u>6/15/87</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's Cemetery</u>	23d. LOCATION CITY OR TOWN COUNTY STATE <u>Laurel P.G. Md.</u>		
24. FUNERAL DIRECTOR NAME <u>Fleck Funeral Home, Inc.</u>		ADDRESS <u>7601 Sandy Spring Rd.</u>		25a. DATE REC'D. BY REGISTRAR <u>JUN 18 1987</u>	25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of cause.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 18004

FOR 1. STATE -REGISTRAR		VIRGIE G. DULANEY		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST VIRGIE G. DULANEY		2a. DATE OF DEATH MONTH DAY YEAR JUNE 1 1987		2b. HOUR 12:05 AM	
3. SEX FEMALE	4. RACE CAUC.	5. DATE OF BIRTH MONTH DAY YEAR JUNE 17-1899		6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS	
7a. BIRTHPLACE (COUNTRY) VA.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's Co. MD	
10. CITY OR TOWN OF DEATH Laurel	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Greater Laurel Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY HOME
13a. STATE MARYLAND	13b. COUNTY HOWARD	13c. CITY OR TOWN CLARKSVILLE	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 6734 SURREY LANE 21029	
14. FATHER'S NAME FIRST MIDDLE LAST JAMES R. DICKERSON		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNIE L. DICKERSON			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 217-09-2052		17. INFORMANT ADDRESS JAMES W. DULANEY 6734 SURREY LANE CLARKSVILLE, MD. 21029	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Adenocarcinoma of Lung Congestive Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>adenocarcinoma of Lung</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Pleural effusion</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART II)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) this hospital attended the deceased from <u>5/19</u> , 19 <u>87</u> , to <u>June 1</u> , 19 <u>87</u> , that (2) (we) last saw the deceased alive on <u>5/19</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (b) (we) (did) (did not) see the body after death.					
21a. SIGNATURE <u>John Marselis</u>		DEGREE		22c. DATE SIGNED <u>6/1/87</u>	
21b. PHYSICIAN'S NAME (TYPE OR PRINT) <u>John Marselis</u>		22e. ADDRESS <u>14333 Laurel Drive Rd Suit 307 20708</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 6/3/87		23c. NAME OF CEMETERY OR CREMATORY LAKE VIEW MEMORIAL PK. SYKESVILLE CARROLL MARYLAND	
23d. LOCATION CITY OR TOWN COUNTY STATE		24. FUNERAL DIRECTOR LEROY M. & RUSSELL C. WITZKE FUNERAL HOMES P.A. 1630 EDMONDSON AVENUE, CATONSVILLE, MD. 21228			
25a. DATE RECD BY REGISTRAR JUN 2 1987		25b. REGISTRAR'S SIGNATURE <u>Julia Gordon-Randall</u>			

20N COTTON FIBER

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 18005

REG. NO.

1. FOR
STATE
REGISTRAR1. DECEASED NAME
(TYPE OR PRINT)FIRST MIDDLE LAST
ELEANOR B. (Bessie) EASTON2a. DATE OF DEATH MONTH DAY YEAR
06-05-872b. HOUR
10PM M

3. SEX

Female

4. RACE

Black

5. DATE OF BIRTH

MONTH DAY YEAR
08 14 '25

6. AGE (IN YEARS LAST BIRTHDAY)

61

IF UNDER 1 YEAR

MONTHS DAYS

IF UNDER 24 HRS.

HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

Maryland

7b. CITIZEN OF WHAT COUNTRY?

USA

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

PRINCE GEORGE'S

MD.

10. CITY OR TOWN OF DEATH

CHEVERLY

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

PRINCE GEORGE'S HOSPITAL CENTER

12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)

12b. KIND OF BUSINESS OR INDUSTRY

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

Maryland

13b. COUNTY

Prince Geo Suitland

13c. CITY OR TOWN

13d. INSIDE CITY LIMITS?

YES ☒ NO ☐

13e. STREET ADDRESS / ZIP CODE

5625 Regency Park Ct. 20746

14. FATHER'S NAME

Thomas

15. MOTHER'S MAIDEN NAME

Henry Brooks

16. WAS DECEASED EVER IN U. S. ARMED FORCES?

(YES, NO OR UNKNOWN)

16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)

220 12 3994

17. INFORMANT

Gloria Swann

ADDRESS

SAA

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a).

Cardio pulmonary Arrest

DUE TO, OR AS A CONSEQUENCE OF

Sepsis pulmonary edema

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost

DUE TO, OR AS A CONSEQUENCE OF

osteomyelitis

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I.

Nonhealing fracture - Chronic renal failure osteodysplasia

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐
AT WORK AT WORK21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from 2-26-87 to 6-5-87, that (I) (we) lost saw the deceased alive on 6-5-87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

Rishpal Singh

DEGREE

MD MRCP

ATTENDING PHYSICIAN ☐MEDICAL DIRECTOR ☐STAFF PHYSICIAN ☐

22c. DATE SIGNED

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

RISHPAL SINGH

22e. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

Burial

23b. DATE

6-10-87

23c. NAME OF CEMETERY OR CREMATORY

Resurrection Cem

23d. LOCATION

Clinton, P.G., Md.

COUNTY

STATE

24. FUNERAL DIRECTOR

Martell Adams, Aquasco Md

25a. DATE REC'D BY REGISTRAR

JUN 18 1987

25b. REGISTRAR'S SIGNATURE

John Decker-Rudolph

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner or coroner should be notified.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 18000

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST <u>Burch</u> LAST <u>EMANUEL EBERHARDT</u> Sr.		2a. DATE OF DEATH MONTH <u>6</u> DAY <u>18</u> YEAR <u>87</u>		2b. HOUR <u>4:15 PM</u>	
3. SEX <u>Male</u>	4. RACE <u>Black</u>	5. DATE OF BIRTH MONTH <u>03</u> DAY <u>14</u> YEAR <u>33</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>54</u> YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Pittsburgh, PA</u>	7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>PRINCE GEORGES</u> MD.	
10. CITY OR TOWN OF DEATH <u>CLINTON</u>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>SOUTHERN Md. Hosp CENTER</u>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Truck Driver</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>Newspaper</u>
13a. STATE <u>Maryland</u>	13b. COUNTY <u>P. G.</u>	13c. CITY OR TOWN <u>Clinton</u>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <u>6807 Killarney Street 20735</u>	
14. FATHER'S NAME FIRST <u>Theophilus</u> MIDDLE <u>W.</u> LAST <u>Eberhardt</u>		15. MOTHER'S MAIDEN NAME FIRST <u>Marie</u> MIDDLE <u>Hightower</u> LAST <u>Hightower</u>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>NO</u>		16b. SOCIAL SECURITY NO. <u>205-24-7358</u>		17. INFORMANT <u>Lucy A. Eberhardt</u> ADDRESS <u>Same as 13 A-E</u>	
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Gastrointestinal bleeding</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Dilated cardiomyopathy, mitral stenosis</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u></u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>6/18/87</u> to <u>6/18/87</u> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <u>6/18/87</u> , and that in my own opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death.					
22b. SIGNATURE <u>John C. Patterson</u>		DEGREE <u>M.D.</u>		22c. DATE SIGNED <u>6/29/87</u>	
22d. PHYSICIAN'S NAME (PRINT) <u>John C. Patterson, M.D.</u>		22e. ADDRESS <u>7501 Surratts Road, Clinton, Md 20735</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>06/22/87</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Resurrection Cemetery</u>	
23d. LOCATION (BY OR TOWN COUNTY STATE) <u>Clinton Prince George's Md.</u>		24. FUNERAL DIRECTOR NAME <u>Lee Funeral Home, Inc.</u> ADDRESS <u>6633 Old Alexander Ferry Rd. Clinton, Md 20735</u>			
25a. DATE REC'D. BY REGISTRAR <u>JUN 24 1987</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked by item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a post-mortem examination required.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. DECEASED NAME (TYPE OR PRINT) James Albert Edelen Sr.					2a. DATE OF DEATH MONTH DAY YEAR June 8, 1987					2b. HOUR M
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Dec. 9, 1908		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD.				
10. CITY OR TOWN OF DEATH Clinton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 12111 Piscataway Road				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Carpenter Ret.		12b. CHIEF BUSINESS OR INDUSTRY Weather Strip Co.		
13a. STATE Maryland		13b. COUNTY P. G.		13c. CITY OR TOWN Clinton		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 12111 Piscataway Rd. 20735		
14. FATHER'S NAME FIRST MIDDLE LAST James Miles Edelen					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Gertrude A. Jenkins					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) 1944-1945		16c. SOCIAL SECURITY NO. 377- 09-0336		17. INFORMANT ADDRESS Millicent C. Edelen Same as 13 A-E				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Atherosclerosis of Brain</u> DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Arteriosclerotic Heart Disease - Systemic Lupus Erythematosus</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <u>6/8</u> 19 <u>87</u> to <u>6/8</u> 19 <u>87</u> that (I) (we) lost saw the deceased alive on <u>6/8</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (If (I) (we) did not view the body after death)										
22b. SIGNATURE <u>R.A. McConaughy</u>					DEGREE <u>MD</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED June 9, 1987	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. R.A. McConaughy					22e. ADDRESS 5618 St. Barnabas Rd. Oxon Hill, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 06/11/87		23c. NAME OF CEMETERY OR CREMATORY St. Mary's Church Cem		23d. LOCATION (CITY OR TOWN) COUNTY Piscataway Prince George's Md.				
24. FUNERAL DIRECTOR NAME Lee Funeral Home, Inc. ADDRESS 6633 Old Alexander Ferry Rd Clinton, Md 20735					25a. DATE REC'D. BY REGISTRAR JUN 10 1987		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

Wm. J. G. J. 1885

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Wm. J. G. J. 1885

Wm. J. G. J. 1885

BP

DHMH - 16 50M 1/81
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use at the burial/funeral permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner who has not signed.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		2a. DATE OF DEATH				2b. HOUR			
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH				2b. HOUR			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. BALTIMORE CITY OR COUNTY OF DEATH	
Female		White		April 20, 1914		73 YRS		PRINCE-GEORGES CO MD	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
N.C.		U.S.A.				Homemaker		Own Home	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		13a. STREET ADDRESS		13b. CITY OR TOWN		13c. COUNTY	
CLINTON		So. Maryland Hospital		Box 320, Lot 66 Hwy #5		20616			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
Maryland		Charles		Bryans Road		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Box 320, Lot 66 Hwy #5	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
Thomas Curry Cates		Minnie Iva Allen		NO		237-28-3856		Sue Baker, 1214 Burlington RD. Roxboro N.C. 27573	
18. CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c)									
PART 1. DEATH WAS CAUSED BY									
IMMEDIATE CAUSE (a) Colon Cancer metastatic to lung									
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (b) stating the underlying cause last									
DUE TO, OR AS A CONSEQUENCE OF									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
		HOUR A.M. MONTH DAY YEAR							
		P.M. 19							
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION		CITY OR TOWN		COUNTY STATE	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				STREET					
22a. I certify that (1) (this hospital) attended the deceased from 5:29 19 87 to 6:1 19 87, that (1) (we) lost saw the deceased alive on 6:1 19 87, and that in my own opinion death occurred on the date and hour and from the causes stated above, (1) (we) did not view the body after death.									
22b. SIGNATURE		DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
William Kent Ours MD								6/2/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS							
William Frost		11701 Livingston RD						Ft. Wash. MD	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		CITY OR TOWN COUNTY STATE	
Burial		6-4-87		Person Memorial Cem.		Roxboro, N.C. 27573			
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Jack White		JUN 10 1987		James Davidson-Randall					
Brooks & White Fun. Home		Roxboro, NC							



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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 18009

FOR
1- STATE
REGISTRAR

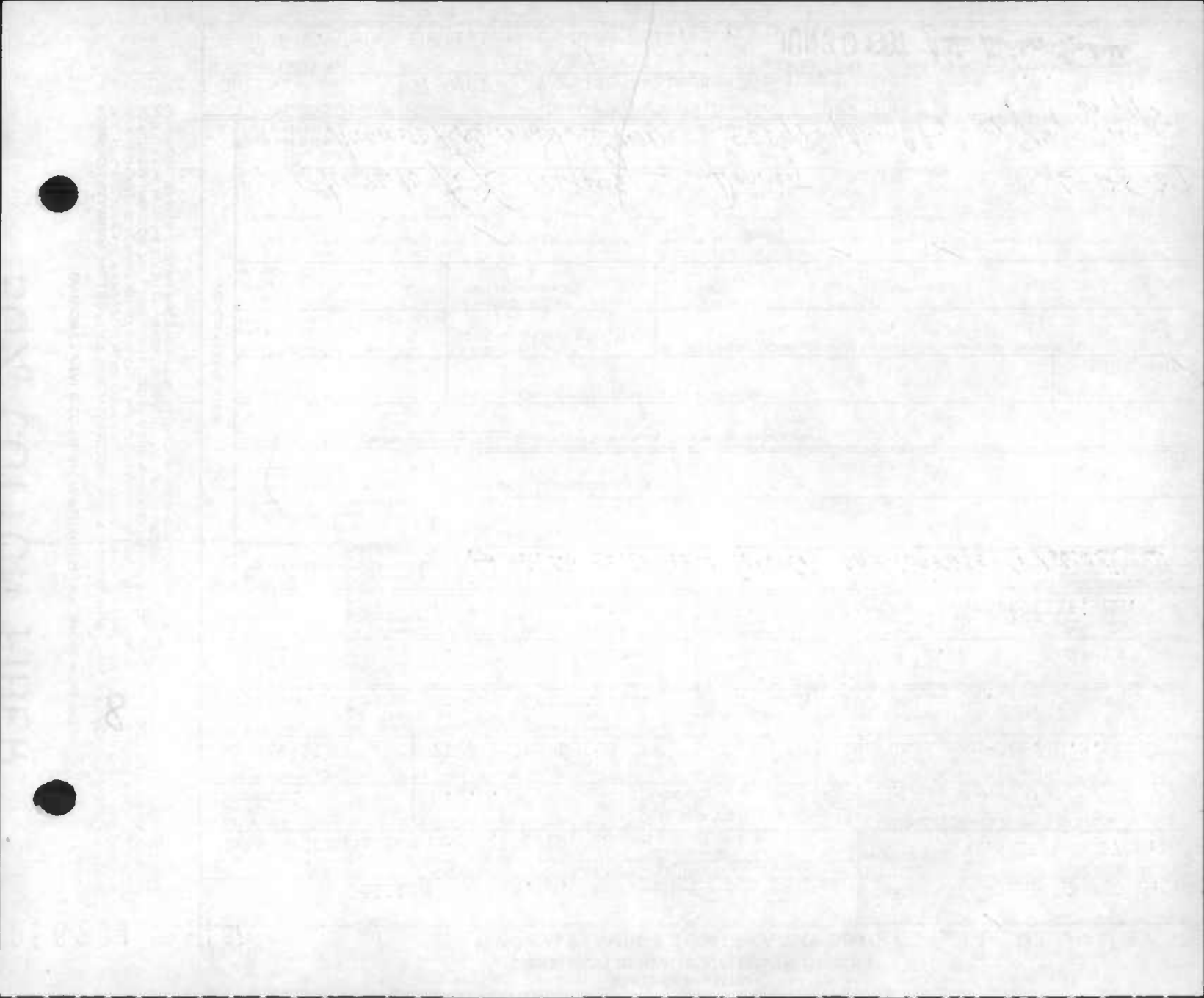
1 DECEASED NAME (TYPE OR PRINT) William A. A. Edgington			2a DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR June 27 19 87			2b HOUR 6:10 P.		
3 SEX Male	4 RACE Caucasian	5 DATE OF BIRTH MONTH DAY YEAR March 26 1919	6 AGE (IN YEARS) LAST BIRTHDAY 68 YRS.	IF UNDER 1 YR MONTHS DAYS HOURS MIN	IF UNDER 24 HRS.	2c DATE PRONOUNCED DEAD June 27 19 87	2d HOUR 6:10 P.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Missouri		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD		
10 CITY OR TOWN OF DEATH Forestville		11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 7109 Beltz Drive				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Chief Radioman-Ret.		
12b KIND OF BUSINESS OR INDUSTRY U.S. Navy		13a STATE Maryland		13b COUNTY Prince George		13c CITY OR TOWN Forestville		
14 FATHER'S NAME FIRST MIDDLE LAST William R. Edgington		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bonnie J. McCombs		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS 7109 Beltz Dr. 20747		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes		16b SOCIAL SECURITY NO. WWII Korea 551-38-1040		17 INFORMANT Patricia Edgington		ADDRESS 7109 Beltz Dr. Forestville, Md.		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Dilated arteriosclerotic cardiovascular disease</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).								
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)				
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE <i>Augusto P. Rodriguez</i>		TITLE (SPECIFY) M.D. <i>Physician</i>		MEDICAL EXAMINER		DATE SIGNED 6-28-87		
EXAMINER'S NAME (TYPE OR PRINT) Augusto P. Rodriguez MD		ADDRESS 5009 Layman Ct., Camp Springs, Md.						
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 6/30/87		23c. NAME OF CEMETERY OR CREMATORY Maryland Veterans Cemetery		23d. LOCATION CITY OR TOWN Cheltenham P.G. Maryland		
24 FUNERAL DIRECTOR NAME George P. Kalas		ADDRESS 6160 Oxon Hill Rd.		25a. DATE REC'D. BY REGISTRAR JUN 30 1987		25b. REGISTRAR'S SIGNATURE <i>Julia Anderson-Rodriguez</i>		

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, 3, 4, AND 5 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. GIVE PAGES 1, 2, 3, 4, AND 5 TO YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84
25M

BP
DHMH - 17
(VR A15 ME (5))



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 18010

1. FOR STATE REGISTRAR			2a. DATE OF DEATH			2b. HOUR		
1. DECEASED NAME (TYPE OR PRINT)			3. SEX			4. RACE		
ARLENE F EDWARDS			Female			White		
5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. BALTIMORE CITY OR COUNTY OF DEATH		
July 31, 1935			51 YRS			PRINCE GEORGES CO.		
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			9. CITIZEN OF WHAT COUNTRY?			10. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION		
Washington DC			USA			So. Maryland Hospital		
11. CITY OR TOWN OF DEATH			12. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13. STREET ADDRESS / ZIP CODE		
CLINTON			Maryland Charles Waldorf			3006-17 Gallery PLACE		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16. SOCIAL SECURITY NO.		
Walter L Allen			Frances McHale			578-46-4062		
17. DECEASED EVER IN U.S. ARMED FORCES?			18. INFORMANT			19. ADDRESS		
No			Cynthia Holley			5201 Morris Ave Suitland, Maryland		
20. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								
PART 1. DEATH WAS CAUSED BY:								
IMMEDIATE CAUSE (a) <u>RESPIRATORY FAILURE</u>								
DUE TO, OR AS A CONSEQUENCE OF								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								
(b) <u>EXTENSIVE pulmonary METASTASIS</u>								
DUE TO, OR AS A CONSEQUENCE OF								
(c) <u>CARCINOMA of LUNG</u>								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. a								
<u>MALNUTRITION, CHRONIC OBSTRUCTIVE PULMONARY Disease</u>								
21a. DATE OF OPERATION			21b. CONDITION FOR WHICH OPERATION WAS PERFORMED			21c. AUTOPSY?		
						YES <input type="checkbox"/> NO <input type="checkbox"/>		
21d. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21e. TIME OF INJURY			21f. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)		
			HOUR A.M. MONTH DAY YEAR					
			P.M. 19					
21g. INJURY OCCURRED			21h. PLACE OF INJURY			21i. LOCATION		
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			(AT HOME STREET, FACTORY OFFICE, FARM, ETC.)			STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>6/19</u> , 19 <u>87</u> , to <u>6/22</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>6/22</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE						DEGREE		22c. DATE SIGNED
<u>Helen Capone</u>						M.D.		<u>June 23/87</u>
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS		
<u>Helen D. CAPONE</u>						<u>7501 SURREATTS RD CLINTON MD 20735</u>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY		
Burial			25 June 1987			Cedar Hill Cemetery Suitland PG Md		
24. FUNERAL DIRECTOR NAME			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
Robert E Wilhelm Funeral Home			JUN 30 1987			<u>Julia Gordon Randall</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87-18011
REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JASPER J. ELLIOTT			2a. DATE OF DEATH MONTH DAY YEAR 06-04-87		2b. HOUR 1.11A M
3 SEX Male	4 RACE Black	5 DATE OF BIRTH MONTH DAY YEAR 10 14 30		6 AGE (IN YEARS LAST BIRTHDAY) 56 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS: HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES MD.	
10 CITY OR TOWN OF DEATH CHEVERLY	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGES HOSPITAL CENTER		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Custodial		12b. KIND OF BUSINESS OR INDUSTRY Private
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN Maryland P. Georges Landover			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 7635 Muncy Road 20785
14. FATHER'S NAME FIRST MIDDLE LAST Jasper Elliott, Sr.		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Pinky McNeil		ADDRESS 7321 Landover Rd.	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1951 - 1953 246-48-3436		17 INFORMANT Lloyd Elliott	

18. CAUSE OF DEATH (Enter only one cause per line for 1a), 1b), and 1c)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Septic Shock

Conditions, if any, which gave rise to immediate cause 1a), stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF

b) Alcoholic Hepatitis &

DUE TO, OR AS A CONSEQUENCE OF

c) Alcohol Abuse

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 1a)

Coagulopathy; Gastrointestinal Bleeding; Renal Tubular Acidosis

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>5.18.87</u> to <u>6.4.87</u> , that (I) (we) last saw the deceased alive on <u>6.3.87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>J. S. Mann</u>		DEGREE		22c. DATE SIGNED <u>6.6.87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JATINDER P. S. MANN		22e. ADDRESS c/o P. G. G. Hospital; Cheverly MD, 20785			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE June 10, 1987	23c. NAME OF CEMETERY OR CREMATORY Cheltenham	23d. LOCATION CITY OR TOWN COUNTY STATE Cheltenham P.G. Md.
24. FUNERAL DIRECTOR NAME J. B. Jenkins Funeral Home		25a. DATE REC'D. BY REGISTRAR JUN 15 1987	25b. REGISTRAR'S SIGNATURE <u>Julia Linder-Rublee</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death, with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and advised.

Form with multiple sections and fields, including a large table area. The text is faint and mostly illegible due to the quality of the scan. The form appears to be a standard administrative or financial document.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 7 1 8 0 1 2

REG. NO.

1. FOR
STATE
REGISTRAR1. DECEASED NAME
(TYPE OR PRINT)FIRST MIDDLE LAST
GERALD M. EMERY Sr.2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR
06 18 87 12 55 PM3. SEX
Male4. RACE
Caucasian5. DATE OF BIRTH YEAR
01/08/306. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR IF UNDER 24 HRS
57 MONTHS DAYS HOURS MIN7a. BIRTHPLACE (STATE OR FOREIGN)
Frankfort, Indiana7b. CITIZEN OF WHAT COUNTRY?
U.S.A.8. MARRIED ☒ NEVER MARRIED ☐
WIDOWED ☐ DIVORCED ☐9. BALTIMORE CITY OR COUNTY OF DEATH
PRINCE GEORGES COUNTY MD.10. CITY OR TOWN OF DEATH
FREDERICK11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
PRINCE GEORGES HOSPITAL CENTER12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Manager12b. KIND OF BUSINESS OR INDUSTRY
Soda

13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

Maryland

13b. COUNTY

Charles

13c. CITY OR TOWN

Waldorf

13d. INSIDE CITY LIMITS?

YES ☒ NO ☐

13e. STREET ADDRESS / ZIP CODE

1208 Wellfleet Dr. 20601

14. FATHER'S NAME

FIRST MIDDLE LAST
Archibald

Emery

15. MOTHER'S MAIDEN NAME

FIRST MIDDLE LAST
Rena

Belle

Randolph

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)

Yes

16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)

310-24-4662

17. INFORMANT

Mary Margaret Emery Same as 13 A-E

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)
PART I. DEATH WAS CAUSED BYIMMEDIATE CAUSE (a) Sepsis

DUE TO, OR AS A CONSEQUENCE OF

(b) Brain Stem Infection

DUE TO, OR AS A CONSEQUENCE OF

(c) Prostate MetastasisAPPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

1 day

3 months

20 years

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1

Prostate Metastasis

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☒20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER)21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐
AT WORK AT WORK21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)21f. LOCATION
STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last
saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

DEGREE

ATTENDING
PHYSICIAN ☒MEDICAL
DIRECTOR ☐STAFF
PHYSICIAN ☐

22c. DATE SIGNED

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

GABRIEL JAFFE, M.D.

22e. ADDRESS

7500 Harwood Pkwy Greenbelt Md

23a. BURIAL, CREMATION, REMOVAL
(TYPE OR PRINT)

Burial

23b. DATE
06/24/8723c. NAME OF CEMETERY OR CREMATORY
Arlington National Cemetery23d. LOCATION
CITY OR TOWN COUNTY STATE
Arlington Arl. Va.

24. FUNERAL DIRECTOR

NAME Lee Funeral Home, Inc.

25a. DATE REC'D. BY REGISTRAR

JULY 24 1987

25b. REGISTRAR'S SIGNATURE

Julia Tison-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They must remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified above.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8718013

1- FOR STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH	
JOHN EDWARD ESLIN JR		6 6 87 2:35pm	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)
Male	Caucasian	Nov. 14, 1923	63 YRS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH
Wash., DC	USA		PRINCE GEORGES COUNTY MD.
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
CLINTON MD	SOUTHERN MARYLAND HOSPITAL	Salesman	Whlse. Flst.
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?
Maryland	Pr. George	Temple Hills	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME	13e. STREET ADDRESS / ZIP CODE	
John Edward Eslin SR.	Mamie Pearl Jenkins	20748 8601 Temple Hills Rd. #50	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS	
Yes	WWII	Helen J. Eslin - same as # 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:			HOURS
IMMEDIATE CAUSE (a) — <u>CARDIOPULMONARY ARREST</u>			
DUE TO, OR AS A CONSEQUENCE OF			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			Months.
b) <u>TERMINAL METASTATIC LIPOSARCOMA</u>			
DUE TO, OR AS A CONSEQUENCE OF			
OF ABDOMEN.			
c)			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
	HOUR A.M. MONTH DAY YEAR		
	P.M. 19		
21d. INJURY OCCURRED	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION	
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>May 22</u> , 19 <u>87</u> to <u>6-6-</u> , 19 <u>87</u> , that (I) (we) lost			
saw the deceased alive on <u>6-6-</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated			
above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE	DEGREE	22c. DATE SIGNED	
<i>Peter W. Yim</i>	M.D.	June 7'87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS		
PETER W. YIM M.D.	7900 OLD BRANCH AVE. SUITE 101		
	CLINTON, MARYLAND 20735		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION
Burial	6-9-87	Trinity Memorial	Waldorf Charles Md.
24. FUNERAL DIRECTOR	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE	
Huntt Funeral Home	JUN 10 1987	<i>John A. Henderson</i>	
NAME	ADDRESS		
P. O. Box 156	Waldorf, Md. 20601		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

REV. 10-10-58

1. *[Faint handwritten text]*

2. *[Faint handwritten text]*

3. *[Faint handwritten text]*

4. *[Faint handwritten text]*

5. *[Faint handwritten text]*

6. *[Faint handwritten text]*

7. *[Faint handwritten text]*

8. *[Faint handwritten text]*

9. *[Faint handwritten text]*

10. *[Faint handwritten text]*



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 18014

REG. NO.

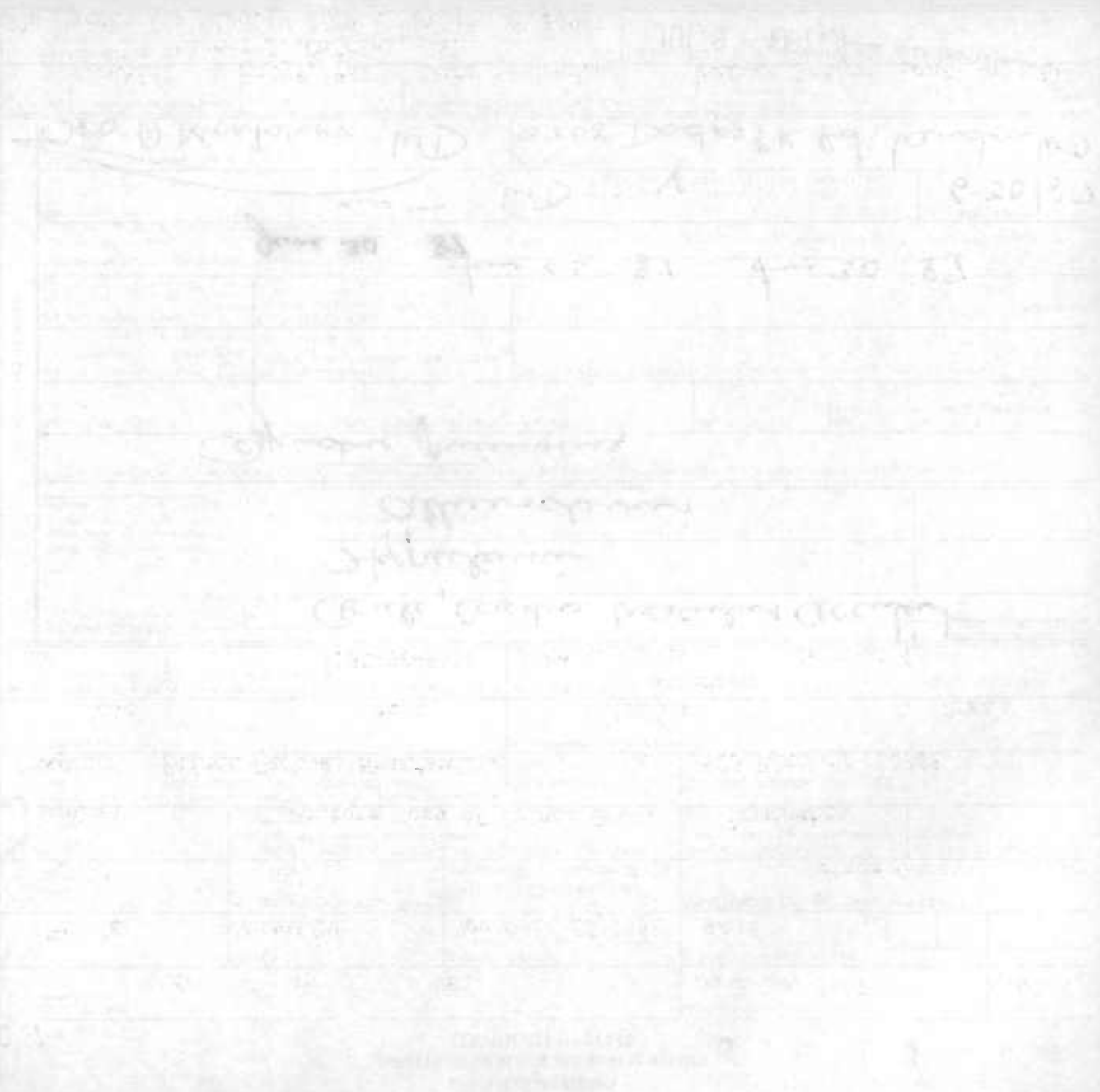
1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MARY MIDDLE N LAST FEL			2a. DATE OF DEATH MONTH DAY YEAR June 30, 1987		2b. HOUR 6:00 A _M
3 SEX Female	4 RACE Caucasian	5 DATE OF BIRTH MONTH DAY YEAR November 20, 1892		6 AGE (IN YEARS LAST BIRTHDAY) 94 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (COUNTRY) STATE OR FOREIGN Hungary	7b. CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Prince George's Co. MD.	
10. CITY OR TOWN OF DEATH Lanham	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) AMI Doctors Hosp of Prince Geos.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) homemaker		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Maryland			13b. COUNTY Prince Georges	13c. CITY OR TOWN Hyattsville	
14. FATHER'S NAME FIRST MIDDLE LAST Josef Horak			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Kristina Rass		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 105-38-5515		17 INFORMANT grandson John K. Nemes ADDRESS same as 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute, Coronary Vascular Accident</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c) <u>Emphysema</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>June 23, 1987</u> to <u>June 30, 1987</u> , that (I) (we) last saw the deceased alive on <u>June 30, 1987</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>[Signature]</u>		DEGREE <u>MD</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 6-30/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Geo A. Montomery		22e. ADDRESS 3308 Doodle PK Rd Landover MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial	23b. DATE July 3, 1987	23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven		23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring Mont MD	
24. FUNERAL DIRECTOR NAME Francis J. Collins, Jr. 500 University Blvd., W Silver Spring, MD 20901		25a. DATE REC'D. BY REGISTRAR JUL 8 1987			

THE UNIVERSITY OF CHICAGO LIBRARY

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EXHIBIT 11856



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and collectively filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified. If other

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Odilia Flores					2a. DATE OF DEATH MONTH DAY YEAR June 07, 1987					2b. HOUR 12:09 A	
3 SEX Female		4 RACE Hispanic		5. DATE OF BIRTH MONTH DAY YEAR October 23, 1927		6 AGE (IN YEARS LAST BIRTHDAY) 59 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) El Salvador		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Prince Georges County MD.					
10 CITY OR TOWN OF DEATH Laurel		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Greater Laurel Beltsville Hospital				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Domestic			
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE COUNTY CITY OR TOWN MD Montgomery Silver Spring					13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 310 Domer Ave., 20910				
14. FATHER'S NAME FIRST MIDDLE LAST Gabareil Flores					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Eufemia Reyes						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b SOCIAL SECURITY NO Unknown		17 INFORMANT ADDRESS Rosa Menendez, 18536 Bowie Mill, Olney, MD 20832							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sudden Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) chronic renal failure DUE TO, OR AS A CONSEQUENCE OF (c) Hypertensive Cardiovascular disease										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE						
22a I certify that (I) (this hospital) attended the deceased from 4-25-87 to 6-6-87 , that (I) (we) last saw the deceased alive on 6-6-87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE Dr. Jalal Fatemi					DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 6-7-87		
22d PHYSICIAN'S NAME (TYPE OR PRINT) Dr Jalal Fatemi					22e ADDRESS 5632 Annapolis Rd #12 BLADENSBURG MD						
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 6-10 -87		23c NAME OF CEMETERY OR CREMATORY Parklawn		23d LOCATION CITY OR TOWN COUNTY STATE Rockville, Montgomery Co., MD				
24 FUNERAL DIRECTOR (NAME) W. W. CHAMBERS CORP., Silver Spring, MD					25a. DATE REC'D. BY REGISTRAR		25b REGISTRAR'S SIGNATURE Juan F. ...				

BP

JUN 15 1987



ALTON FLEET

ALTON FLEET

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Helen V. Foley			2a. DATE OF DEATH MONTH DAY YEAR June 7, 1987		2b. HOUR 11:30pM
3. SEX female	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR July 10 1905		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (COUNTRY) Washington, D.C.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD.	
10. CITY OR TOWN OF DEATH Hyattsville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sacred Heart Home, Inc.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Adm. Asst.		12b. KIND OF BUSINESS OR INDUSTRY Patent Attorneys
13a. STATE Maryland	13b. COUNTY Montgomery	13c. CITY OR TOWN Silver Spring	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 8505 Springvale Terrace 20910	
14. FATHER'S NAME FIRST MIDDLE LAST Asbury N. Thompson		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marcella Eckels			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no		16b. SOCIAL SECURITY NO. 577-10-2085		17. INFORMANT husband Francis X. Foley ADDRESS 8505 Springvale Terr. Silver Spring, Md. 20910	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>MYOCARDIAL INFARCTION</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>IMMEDIATE</u> <u>IMMEDIATE</u>
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>ALZHEIMER'S DISEASE</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>7/1</u> , 19 <u>82</u> , to <u>6/7</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>5/31</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Kevin G. Nealon				22c. DATE SIGNED 6/8/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Kevin G. Nealon, M.D.				22e. ADDRESS 916 19th St. N.W., Washington, D.C. 20006	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE June 11, 1987		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery	
24. FUNERAL DIRECTOR NAME Francis J. Collins, Jr.		23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring Montgomery Md.		25a. DATE REC'D BY REGISTRAR JUN 15 1987	
500 University Blvd. West, Silver Spring, Md. 10901					

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGE NO. AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM-3. RETAIN PAGE 4 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 18017

FOR 1- STATE REGISTRAR		DECEASED NAME (TYPE OR PRINT)		FIRST James L.		MIDDLE Francis		LAST France		2a. DATE KNOWN OF DEATH ESTI. MATED		MONTH June 3, 1987		DAY 8		YEAR 1987		2b. HOUR 12:00	
3. SEX M		4. RACE Blk		5. DATE OF BIRTH MONTH DAY YEAR Nov. 24, 1974		6. AGE (IN YEARS) LAST BIRTHDAY 14 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD June 3, 1987		MONTH DAY YEAR		2d. HOUR 4 M			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges		MD											
10. CITY OR TOWN OF DEATH Laurel		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Frederick Laurel Belkville Hosp		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) B & O Railroad		12b. KIND OF BUSINESS OR INDUSTRY Retired													
13a. STATE Maryland		13b. COUNTY Prin		13c. CITY OR TOWN Laurel		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 507 8th St. Laurel Maryland											
14. FATHER'S NAME FIRST MIDDLE LAST Lewis		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah J. Berry		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 213-03-2029		17. INFORMANT Mary E. France		ADDRESS 507 8th St. Laurel, MD									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Dis.</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (b) <u>Chronic Myocardial Dis.</u> DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 <u>None</u>																			
19a. DATE OF OPERATION <u>None</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE															
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .		22b. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																	
ACTUAL SIGNATURE <u>[Signature]</u>		TITLE (SPECIFY) M.D. <u>Dep.</u>		MEDICAL EXAMINER		DATE SIGNED June 3, 1987													
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6-8-87		23c. NAME OF CEMETERY OR CREMATORY France Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE COOKESVILLE Maryland													
24. FUNERAL DIRECTOR NAME Bailey Funeral Home		ADDRESS 1348 N. Calhoun St. 21217		25a. DATE REC'D. BY REGISTRAR JUN 10 1987		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>													

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8718018

FOR
STATE
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) Willie FRAYER, Sr.			2a DATE OF DEATH MONTH DAY YEAR June 13, 1987		2b HOUR 10:46PM						
3 SEX Male		4 RACE Black		5 DATE OF BIRTH MONTH DAY YEAR Nov. 24, 1921		6 AGE (IN YEARS LAST BIRTHDAY) 65 YRS		7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		8 IF UNDER 72 HRS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD					
10 CITY OR TOWN OF DEATH Lanham		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Doctors' Hospital of Pr. Geo. Co.				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b KIND OF BUSINESS OR INDUSTRY			
13a STATE Maryland		13b COUNTY P.G.		13c CITY OR TOWN Seat Pleasant		13d INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO		13e STREET ADDRESS / ZIP CODE 1113 Carrington Avenue 20743			

14 FATHER'S NAME FIRST MIDDLE LAST James Frayer		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Beatrice Unknown			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b SOCIAL SECURITY NO. 242 20 4459		17 INFORMANT Beatrice Frayer-wife-1113 Carrington	

18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Hepatic Failure</u> (b) <u>Septicemia</u> (c) <u>Internal Bleeding</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Liver Disease</u> (c) <u>Alcohol</u> DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>year</u> <u>year</u>	
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PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Chronic Alcoholism</u>			
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19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
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21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
--	--	---	--	---	--

21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
---	--	---	--	--	--

22a I certify that (I) (this hospital) attended the deceased from <u>6-13</u> 19 <u>87</u> , to <u>6-13</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>6-13</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) see the body after death.					
--	--	--	--	--	--

22b SIGNATURE <u>Ohannes Sahakian</u>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 6-15-87	
--	--	--------	--	--	--	----------------------------	--

22d PHYSICIAN'S NAME Ohannes Sahakian M.D.		22e ADDRESS 5632 Annapolis Rd., Bladensburg, Md. 20710					
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23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE June 19, 1987		23c NAME OF CEMETERY OR CREMATORY Hamrony Memorial Park Landover, Maryland		23d LOCATION CITY OR TOWN COUNTY STATE	
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24 FUNERAL DIRECTOR NAME Stewart Funeral Home-4001 Benning Road, N.E.		25a DATE REC'D BY REGISTRAR JUN 24 1987		25b REGISTRATION NO. JULIA DORRANCE KENNEDY	
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of the

BP

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM-1, RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

13019

1- FOR STATE REGISTRAR		2a DATE KNOWN OF DEATH		MONTH DAY YEAR		2b HOUR	
1 DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		6/ 14/ 19 87		M	
Robert Freeman							
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (IN YEARS)	IF UNDER 1 YR	IF UNDER 24 HRS.	2c DATE PRONOUNCED DEAD	2d HOUR
MALE	BLK.	10-28-44	42 YRS			6/14/ 87	12:05 P M
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH		
D.C.	U.S.A.				Prince George's County, MD		
10 CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY	
Cheverly	Prince George's General Hospital			PLUMBER		N/A	
13a USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)	13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS?	13e STREET ADDRESS			
D.C.		WASH.	YES <input type="checkbox"/> NO <input type="checkbox"/>	4431-POWERS ST. N.E.			
14 FATHER'S NAME	15 MOTHER'S MAIDEN NAME						
WILLIAM	ANNIE WALKER						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	16b SOCIAL SECURITY NO.		17 INFORMANT ADDRESS				
	169-34-1944		DEANNA FREEMAN - SAME AS 13c				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a)							
Multiple Stab Wounds							
DUE TO, OR AS A CONSEQUENCE OF							
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.							
(b)							
DUE TO, OR AS A CONSEQUENCE OF							
(c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY?	
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
		1:30 PM 6/14/ 19 87		subject stabbed			
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f LOCATION			
		house		707 Division Ave., N.E., Washington, D.C.			
22a I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> .							
ACTUAL SIGNATURE		TITLE (SPECIFY)				DATE SIGNED	
Dennis F. Smyth, MD.		Assistant MEDICAL EXAMINER				6/15/87	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS					
Dennis F. Smyth, MD.		111 Penn St.					
23a BURIAL, CREMATION, REMOVAL (SPECIFY)	23b DATE	23c NAME OF CEMETERY OR CREMATORY		23d LOCATION CITY OR TOWN		STATE	
BURIAL	6-22-87	Harmony Mem.		Highland		D.C.	
24 FUNERAL DIRECTOR NAME	ADDRESS		25a DATE REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE		
H.S. Williams + Sons - Inc.	4925 N. H. St.		JUN 18 1987		Julia Davidson-Randall		



50% COLLECTIBLES

FRONT

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 7 1 8 0 2 0
REG. NO.1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ELLEN B GARCIA			2a. DATE OF DEATH MONTH DAY YEAR 6-25-87		2b. HOUR 4:30p. M	
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR March 23, 1919		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Connecticut		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		
10. CITY OR TOWN OF DEATH CLINTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SOUTHERN MARYLAND HOSPITAL		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES COUNTY MD.		
12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY Prince George's		13c. CITY OR TOWN Suitland		
14. FATHER'S NAME FIRST MIDDLE LAST Chauncey Maish		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Freda Stradinger		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. n/a		17. INFORMANT (son) Gordon Pracht		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Breast cancer with chest wall and liver metastases</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 yr		PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>June 84</u> to <u>June 87</u> that (I) (we) lost saw the deceased alive on <u>6-25</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) not view the body after death.						
22b. SIGNATURE <u>K. Y. Young, M.D.</u>		DEGREE		22c. DATE SIGNED 6-26-87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) K. Y. Young, M.D.		22e. ADDRESS 8126 Woodyard Rd # 201 Clinton, Md 20734				
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE June 29, 1987		23c. NAME OF CEMETERY OR CREMATORY Chansford Church Cem.		
23d. LOCATION CITY OR TOWN COUNTY STATE		24. NAME OF FUNERAL DIRECTOR Lee Funeral Home, Inc. 16633 Old Alexander Ferry Rd., Clinton, MD 20735				
25a. DATE REC'D. BY REGISTRAR JUL 01 1987		25b. REGISTRAR'S SIGNATURE <u>Julia Davidson</u>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18, the cause of death, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed in the funeral director's office. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified (not at once).

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR		REG. NO. 6718021							
1 DECEASED NAME (TYPE OR PRINT) AKA <u>Sister Regina</u> FIRST <u>Alfred</u> MIDDLE <u>Gelinas</u> LAST <u>RJM</u>				2a DATE OF DEATH MONTH <u>June</u> DAY <u>12</u> YEAR <u>1987</u>		2b HOUR <u>9:20</u> MIN <u>M</u>			
3 SEX <u>Female</u>		4 RACE <u>Caucasian</u>		5 DATE OF BIRTH MONTH <u>March</u> DAY <u>31</u> YEAR <u>1895</u>		6 AGE (IN YEARS LAST BIRTHDAY) <u>92</u> YRS		IF UNDER 1 YEAR IF UNDER 24 HRS	
7a BIRTHPLACE (COUNTRY) <u>Canada</u>		7b CITIZEN OF WHAT COUNTRY? <u>USA</u>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <u>Prince George's</u> MD.			
10 CITY OR TOWN OF DEATH <u>Hyattsville</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Regina Convent</u>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Cook</u>		12b KIND OF BUSINESS OR INDUSTRY <u>Religious</u>			
13a STATE <u>Maryland</u>		13b COUNTY <u>Pr. Geo.</u>		13c CITY OR TOWN <u>Hyattsville</u>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE <u>8910 Riggs Road</u> <u>20783</u>	
14 FATHER'S NAME FIRST <u>Alfred</u> MIDDLE <u>Gelinas</u> LAST <u>Eleonore</u>				15 MOTHER'S MAIDEN NAME FIRST <u>Eleonore</u> MIDDLE <u>Lesieur</u> LAST <u>Lesieur</u>					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u>		16b SOCIAL SECURITY NO. <u>087-42-8417</u>		17 INFORMANT <u>Sister Superior</u> ADDRESS <u>Same as 13</u>					
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Respiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Carcinomatous</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) <u>Carcinoma of the Pancreas</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR <u>A.M.</u> MONTH <u>19</u> DAY <u>19</u> P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>Dec</u> , 19 <u>85</u> , to <u>June</u> , 19 <u>87</u> , that (I) (we) lost the deceased alive on <u>June 11</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>[Signature]</u>				DEGREE <u>MD</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>June 13, 1987</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>MARK K LI</u>				22e. ADDRESS <u>1721 University Blvd W, Wheaton MD 20902</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>Jun. 15, 1987</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mother St. Vincent</u>		23d. LOCATION CITY OR TOWN <u>Adelphi</u> COUNTY <u>Pr. Geo.</u> STATE <u>Maryland</u>			
24 FUNERAL DIRECTOR NAME <u>Francis J. Collins, Jr.</u>				25a. DATE REC'D. BY REGISTRAR <u>JUN 18 1987</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			
500 University Blvd., W. Silver Spring, Md. 20901									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows only injury, or other traumatic event, the medical examiner may be notified of this.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>RITA GILCHRIST</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>6-8-87</i>			2b. HOUR MIN. <i>5:26 A</i>	
3. SEX <i>Female</i>		4. RACE <i>Black</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>Nov 23 1943</i>		6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS <i>43</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Washington, D.C.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>PRINCE GEORGES CO. MD</i>	
10. CITY OR TOWN OF DEATH <i>Clinton</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>SO. MARYLAND HOSPITAL</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Secretary</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Govt</i>	
13a. STATE <i>Maryland</i>		13b. COUNTY <i>PG</i>		13c. CITY OR TOWN <i>Upper Marlboro</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>William A. Adams</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Ruth E. Williams</i>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>No N/A</i>			
17a. SOCIAL SECURITY NO. <i>579 58 5138</i>		17. INFORMANT ADDRESS <i>Upper Marlboro, Md</i> <i>Eddie L. Gilchrist/16707 Wardlow Rd</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiopulmonary Arrest</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>CABREST eg. wet asthma</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <i>Pneumonia Pleurisy Seizure</i>							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i></i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>6-7-87</i> to <i>6-8-87</i> , that (I) (we) lost saw the deceased alive on <i>6-7-87</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>[Signature]</i>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>6-8-87</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>ABUL HASAN ANSARI</i>		22e. ADDRESS <i>8926 Woodward Rd #101 Clinton Md. 20735</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>Jun 12, 1987</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Harmony Memorial</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Landover PG Maryland</i>	
24. FUNERAL DIRECTOR NAME <i>J.B. Jenkins</i>		ADDRESS <i>7474 Landover Rd.</i>		25a. DATE REC'D. BY REGISTRAR <i>JUN 15 1987</i>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

Dr. J. H. ...

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1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 18023

REG. NO.

1. DECEASED NAME FIRST MIDDLE LAST SAMMY GLOVER			2a. DATE OF DEATH MONTH DAY YEAR May 28, 1987		2b. HOUR 2 P		
3. SEX MALE		4. RACE BLACK		5. DATE OF BIRTH APRIL 24, 1902		6. AGE YEARS LAST BIRTHDAY 85 27	
7a. BIRTHPLACE COUNTRY Mississippi		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD.	
10. CITY OR TOWN OF DEATH Lanham		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Maenolie Gardens Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired/Foundry Steel Worker		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE md.		13b. COUNTY Prince Georges		13c. CITY OR TOWN Lanham		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Anthony Glover		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Fannie Miller		16. STREET ADDRESS / ZIP CODE 7022 - 97th Avenue (20706)			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 425-09-6897		17. INFORMANT William M. Glover (son) Lanham, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for a, b, and c.) PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Chronic Renal Failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Severe Anemia DUE TO, OR AS A CONSEQUENCE OF (c) CHE							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1987 1987 1987
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a BPH, Brain Tumor, ASCVO							
19a. DATE OF OPERATION None		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) No		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 5/28/87 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) the hospital attended the deceased from 5/28/87 19 to 5/28/87 19 that I first saw the deceased alive on 5/28/87 19 and that in my opinion death occurred on the date and hour and from the causes stated above. 0 did not view the body after death.							
22b. SIGNATURE JB Patrick III MD		DEGREE		ATTENDING MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5/28/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GB Patrick III MD		22e. ADDRESS 9221 Lakesville Rd Silver Spring, Md 20910					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 06/06/87		23c. NAME OF CEMETERY OR CREMATORY Forest Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Toledo, Lucas County, Ohio	
24. FUNERAL DIRECTOR NAME LATNEY's Funeral Home				25a. DATE REC'D. BY REGISTRAR JUN 30 1987		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	
3831 Georgia Ave. NW; Washington, DC 20011							

20% COTTON FIBER

GREEN BOND



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it is to be filed with the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					87 18024 REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST DONALD R. GOOD					2a. DATE OF DEATH MONTH DAY YEAR 06-10-87			2b. HOUR 12:30 AM	
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR March 30, 1924		6. AGE (IN YEARS LAST BIRTHDAY) 63		7. UNDER 1 YEAR MONTH DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY MD.			
10. CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE'S HOSPITAL CENTER				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Taxi Driver		12b. KIND OF BUSINESS OR INDUSTRY Self Employed	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Prince George's Hills 13c. CITY Temple					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 2408 Keating Street/20748		
14. FATHER'S NAME FIRST MIDDLE LAST William J. Good			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Pansy O. Larrick						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 579-22-5545		17. INFORMANT ADDRESS Mr. Robin Good 3826 Cabana Lane Dallas, Texas 75221					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>VENTRICULAR FIBRILLATION</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>HYPERTENSION</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>SEPSIS</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>COAGULOPATHY, HEPATOPATHY, ANOXIC ENCEPHALOPATHY</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>5/27/1987</u> to <u>6/9/1987</u> , that (I) (we) last saw the deceased alive on <u>6/9/1987</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>K. Raj Ahmed</u>					DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>6/10/87</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>KHAJA AHMED</u>					22e. ADDRESS <u>ONE HOSPITAL DR.</u>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE June 12, 1987		23c. NAME OF CEMETERY OR CREMATORY Mt. Hebron Cemetery		23d. LOCATION Winchester COUNTY Virginia STATE			
24. FUNERAL DIRECTOR Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814						25. DATE RECEIVED BY REGISTRAR JUN 15 1987			
26. REGISTRAR'S SIGNATURE Julia Borden-Randall									

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TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and complies with the law, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) LEWA T GOODE					2a. DATE OF DEATH MONTH DAY YEAR 6 24 87		2b. HOUR 12:15 P.M.				
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 01- 01- 1893		6. AGE (IN YEARS LAST BIRTHDAY) 94 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD.					
10. CITY OR TOWN OF DEATH Adelphi		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION 10111 Riggs Rd Adelphi 20783				12a. USUAL OCCUPATION (TYPE OF WORK OR NAME OF WORKING LIFE) homemaker		12b. KIND OF BUSINESS OR INDUSTRY n/a			
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md 13b. COUNTY Prince George 13c. CITY OR TOWN Adelphi					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 10111 Riggs Rd 20783				
14. FATHER'S NAME FIRST MIDDLE LAST Joseph W Todd					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Shoemaker						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 218-56-9976		17. INFORMANT ADDRESS Ann Stogsdill same as #13							
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>cardio-pulm arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>CHF</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Hypertension</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6 mos</u> <u>7 yrs</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. a <u>CA breast CVA</u>											
19a. DATE OF OPERATION <u>6-24-87</u>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>—</u>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <u>X</u> 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <u>X</u>							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> AT HOME <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <u>X</u>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <u>7701 CARROLL AVE TAKOMA PARK MD</u>							
22a. I certify that (I) (this hospital) attended the deceased from <u>4-15</u> 19 <u>79</u> to <u>6-24</u> 19 <u>87</u> that (I) (we) last saw the deceased alive on <u>6-2</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) did not view the body after death.											
22b. SIGNATURE <u>R.H. SANDTROM MD</u>					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>6-24-87</u>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>R.H. SANDTROM</u>					22e. ADDRESS <u>7701 CARROLL AVE TAKOMA PARK MD 20912</u>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6/27/87		23c. NAME OF CEMETERY OR CREMATORY Stonewall Memory Gardens		23d. LOCATION CITY OR TOWN COUNTY STATE Manassas Prince William Va.					
24. FUNERAL DIRECTOR Donna V. Borgwardt 4400 Powder Mill Rd Beltville Md 20705					25. DATE REC'D. BY REGISTRAR 26. REGISTRAR'S SIGNATURE JUN 26 1987 <u>John D. ...</u>						

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20% COTTON BLEND

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certificate pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

57313 JUN 23 1987 18026

REG. NO.

FOR
1 - STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Lena J. Graney			2a. DATE OF DEATH MONTH DAY YEAR June 18, 1987		2b. HOUR 9:45 A.M.
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR February 19, 1901		6. AGE (IN YEARS (LAST BIRTHDAY)) 86 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 14 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD.	
10. CITY OR TOWN OF DEATH Clinton	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Maryland Hospital Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	12b. KIND OF BUSINESS OR INDUSTRY N/A	
13a. STATE Maryland			13b. COUNTY Prince George	13c. CITY OR TOWN Clinton	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Unknown Grimes			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Laura Biggs		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO 577-38-2558	17. INFORMANT Frederick F. Graney ADDRESS 9611 Glenview Dr. Clinton, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cardiac pulmonary arrest</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <i>Intractable congestive heart failure</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Possible ovarian carcinoma.</i>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a <i>metastases to the abdomen.</i>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>6/3</i> 19 <i>87</i> to <i>6/18</i> 19 <i>87</i> that (I) first saw the deceased alive on <i>6/18</i> 19 <i>87</i> , and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) was <i>did not</i> view the body after death.					
22b. SIGNATURE <i>Glenn R. Jaucian</i>		DEGREE MD		22c. DATE SIGNED <i>6/18/87</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Glenn R. Jaucian, M.D.		22e. ADDRESS 9450 Penn. Ave. #18, Upper Marlboro, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6/20/87	23c. NAME OF CEMETERY OR CREMATORY Bells United Meth.Ch. Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Camp Springs P.G. Maryland
24. FUNERAL DIRECTOR NAME George P. Kalas Funeral Home		ADDRESS 6160 Oxon Hill Rd. Oxon Hill, Md.		25a. DATE REC'D. BY REGISTRAR JUN 22 1987	
25b. REGISTRAR'S SIGNATURE					

BP

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Main body of handwritten text, appearing to be a letter or report.

Date		Description		Amount	
1890	Jan 1	Balance		100.00	
1890	Feb 1	
1890	Mar 1	
1890	Apr 1	
1890	May 1	
1890	Jun 1	
1890	Jul 1	
1890	Aug 1	
1890	Sep 1	
1890	Oct 1	
1890	Nov 1	
1890	Dec 1	
1891	Jan 1	
1891	Feb 1	
1891	Mar 1	
1891	Apr 1	
1891	May 1	
1891	Jun 1	
1891	Jul 1	
1891	Aug 1	
1891	Sep 1	
1891	Oct 1	
1891	Nov 1	
1891	Dec 1	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified to sign.

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 87 18027

1. FOR STATE REGISTRAR		2. DECEASED NAME (TYPE OR PRINT)		3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7a. DATE OF DEATH MONTH DAY YEAR		7b. HOUR P M	
		WILLIAM HAROLD GRIDLEY		MALE		CAUC.		3 28 1897		90 YRS		JUNE 15 1987		12:50 P M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH									
Michigan		USA				Prince George								MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY									
Andrews AFB		Malcolm Grow Medical Center		Retired		US Navy									
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE							
Maryland		Pr. George		Ft. Washington		YES XX NO <input type="checkbox"/>		1200 Firth of Lorne Cr.						26744	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST													
William D. Gridley		Harriet Doolittle													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS									
yes		1918-1963		Lily H. Gridley same as item 13											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CARDIO-RESPIRATORY FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>PNEUMONIA</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.0															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that at this hospital attended the deceased from <u>3 MAY</u> 19 <u>87</u> , to <u>15 JUNE</u> 19 <u>87</u> , that <u>he</u> last saw the deceased alive on <u>15 JUNE</u> 19 <u>87</u> , and that in my opinion death occurred on the date and hour and from the causes stated above. (If deceased did not view the body after death.)															
22b. SIGNATURE <u>Kory C. Cornum</u>		DEGREE CAPTAIN		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 6/16/87									
22d. PHYSICIAN'S NAME (TYPE OR PRINT) KORY C. CORNUM		22e. ADDRESS 524-94-3611 AFSC 9321 Malcolm Grow USAF Medical Center		MALCOLM GROW USAF MED CEN AAFB, MD 20331											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE									
Cremation		6/16/87		Metropolitan Crematory		Alex. Va.									
24. FUNERAL DIRECTOR NAME ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE											
G.P. Kalas 6160 Oxon Hill Rd. Oxon Hill, Md.		JUN 18 1987		<u>Gina Jordan-Rodgers</u>											

BP

059103

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, it should be detached for use as the burial-transit permit. Then please return it to the State Dept. of Health and Mental Hygiene with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 18028

REG NO

FOR STATE REGISTRAR			STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH			REG NO		
1. DECEASED NAME (TYPE OR PRINT) Rev. Anthony R Griffin			2a. DATE OF DEATH MONTH DAY YEAR 6 21 87			2b. HOUR 9:50 AM		
3. SEX M	4. RACE W	5. DATE OF BIRTH MONTH DAY YEAR 12 16 18	6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS			7. IF UNDER 1 YEAR MONTHS DAYS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NY, NY U.S.A.			7b. CITIZEN OF WHAT COUNTRY? USA			8. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD.		
10. CITY OR TOWN OF DEATH Hyattsville			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carroll Manor			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) priest		
13a. STATE Maryland			13b. COUNTY Pr Georges			13c. CITY OR TOWN Hyattsville		
14. FATHER'S NAME FIRST MIDDLE LAST Anthony Griffin			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Dowd			16. STREET ADDRESS / ZIP CODE 4922 La Salle Road 20782		
17a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes			17b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1936-1948			17c. INFORMANT Sec. for Clergy PO Box 29260 Rev Msgr R. Joseph Dooley Wash, DC 20017		
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) General debilitation → probable Arterio Sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Dementia with Cortical Atrophy DUE TO, OR AS A CONSEQUENCE OF (c) 59a1.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 11a and 59a1.					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Recurrent Aspiration Pneumonia								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 6-20-87 1987 to 6-29-87 1987, that (I) (we) last saw the deceased alive on 6-20-87 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE Richard B Kennedy MD			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 6-29-87
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Richard B Kennedy			22e. ADDRESS 1145-19th St NW WASH DC					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial			23b. DATE July 2, 1987			23c. NAME OF CEMETERY OR CREMATORY All Souls		
23d. LOCATION CITY OR TOWN COUNTY STATE Pleasantville Westchester NY			24. FUNERAL DIRECTOR NAME Francis J. Collins, Jr.			25a. DATE RECEIVED BY REGISTRAR JUL 8 1987		
25b. ADDRESS 500 University Blvd., W Silver Spring, MD 20901			25c. SIGNATURE John J. Kennedy					

BP

RECEIVED

1041

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 18029

REG. NO.

FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ROBERT FRANKLIN HALL			2a. DATE OF DEATH MONTH DAY YEAR 06 10 87		2b. HOUR MIN. 12:35 A
3 SEX MALE	4 RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR MARCH 29, 1914		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 73	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) SOUTH CAROLINA	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES COUNTY MD.	
10. CITY OR TOWN OF DEATH CLINTON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Maryland Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) TEXTILE WORKER		12b. KIND OF BUSINESS OR INDUSTRY ROCKHILL CO.
13a. STATE MD.		13b. COUNTY CHARLES	13c. CITY OR TOWN LA PLATA	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST ROBERT WILSON HALL		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST BERTIE VIRGINIA GRIFFIN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 250-03-3020		17. INFORMANT ADDRESS DORIS E. SWEENEY SAME AS #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) stroke Right Side DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Atherosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) Hypertension					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a chronic obstructive Pulmonary Disease					
19a. DATE OF OPERATION N/A		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED N/A		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR N/A N/A 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) N/A	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) N/A		21f. LOCATION STREET CITY OR TOWN COUNTY STATE N/A N/A	
22a. I certify that (I) (this hospital) attended the deceased from 6-3-87 to 6-10-87 , that (I) (we) lost saw the deceased alive on 6-9-87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE A H Faw		DEGREE M.D.		22c. DATE SIGNED 6-10-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Abdul H Fadul		22e. ADDRESS 676 Charles St. Capitol Mt. MD 20646			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 6-13-87		23c. NAME OF CEMETERY OR CREMATORY HERITAGE MEM. PARK	
23d. LOCATION CITY OR TOWN COUNTY STATE WALDORF CHARLES MARYLAND		24. FUNERAL DIRECTOR NAME ADDRESS AREHART FUNERAL HOME, INC. LA PLATA, MD.			
25a. DATE OF REGISTRATION JUN 12 1987		25b. REGISTRAR'S SIGNATURE [Signature]			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 672 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 11b shows any injury, or other traumatic event, the medical examiner must be notified.

Hemman

056462

JUN 11 1987

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR					7. REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) Harry David Hanekamp					2a. DATE OF DEATH MONTH DAY YEAR June 8, 1987					2b. HOUR 12:05P M
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 7 26 1934		6. AGE (IN YEARS LAST BIRTHDAY) 52 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Cumberland, Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges County MD				
10. CITY OR TOWN OF DEATH Laurel		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Greater Laurel Beltsville Hospital				12a. USUAL OCCUPATION (1. TYPE WORK FOR MOST OF WORKING LIFE) Retired		12b. SELF-EMP. OR INDUSTRY Columbia Glass City		
13a. STATE Md.		13b. COUNTY Howard		13c. CITY OR TOWN Columbia		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 9470 Guilford Rd. 21046		
14. FATHER'S NAME FIRST MIDDLE LAST William Howard Hanekamp				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elsie Humphrey						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. 1952-1957 214-28-6876		17. INFORMANT ADDRESS Thelma Hanekamp same as 13e						
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cancer lung</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO, OR AS A CONSEQUENCE OF _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH _____										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. _____										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>June 8</u> , 19 <u>86</u> , to <u>June 8</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>June 8</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) did not view the body after death.										
22b. SIGNATURE <u>Marvin D. Weelt</u>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>6/8/87</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Marvin D. Weelt			22e. ADDRESS 3525 Greenway Cor Anne Greenbelt MD 20770							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 5/12/87		23c. NAME OF CEMETERY OR CREMATORY Meadowridge Cemetery Jessup		23d. LOCATION Howard Md. STATE			
24. FUNERAL DIRECTOR NAME Fleck Funeral Home, Inc. Laurel, Md. 20707					25. DATE OF REGISTRATION JUN 12 1987					

DATE		TIME		LOCATION		WIND		TEMP		HUMID		PRESS		SEA		VIS		CLOUDS		REMARKS	
19	3	15	00	12	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10
<p>1. 1000</p> <p>2. 1000</p> <p>3. 1000</p> <p>4. 1000</p> <p>5. 1000</p> <p>6. 1000</p> <p>7. 1000</p> <p>8. 1000</p> <p>9. 1000</p> <p>10. 1000</p> <p>11. 1000</p> <p>12. 1000</p> <p>13. 1000</p> <p>14. 1000</p> <p>15. 1000</p> <p>16. 1000</p> <p>17. 1000</p> <p>18. 1000</p> <p>19. 1000</p> <p>20. 1000</p> <p>21. 1000</p> <p>22. 1000</p> <p>23. 1000</p> <p>24. 1000</p> <p>25. 1000</p> <p>26. 1000</p> <p>27. 1000</p> <p>28. 1000</p> <p>29. 1000</p> <p>30. 1000</p> <p>31. 1000</p> <p>32. 1000</p> <p>33. 1000</p> <p>34. 1000</p> <p>35. 1000</p> <p>36. 1000</p> <p>37. 1000</p> <p>38. 1000</p> <p>39. 1000</p> <p>40. 1000</p> <p>41. 1000</p> <p>42. 1000</p> <p>43. 1000</p> <p>44. 1000</p> <p>45. 1000</p> <p>46. 1000</p> <p>47. 1000</p> <p>48. 1000</p> <p>49. 1000</p> <p>50. 1000</p> <p>51. 1000</p> <p>52. 1000</p> <p>53. 1000</p> <p>54. 1000</p> <p>55. 1000</p> <p>56. 1000</p> <p>57. 1000</p> <p>58. 1000</p> <p>59. 1000</p> <p>60. 1000</p> <p>61. 1000</p> <p>62. 1000</p> <p>63. 1000</p> <p>64. 1000</p> <p>65. 1000</p> <p>66. 1000</p> <p>67. 1000</p> <p>68. 1000</p> <p>69. 1000</p> <p>70. 1000</p> <p>71. 1000</p> <p>72. 1000</p> <p>73. 1000</p> <p>74. 1000</p> <p>75. 1000</p> <p>76. 1000</p> <p>77. 1000</p> <p>78. 1000</p> <p>79. 1000</p> <p>80. 1000</p> <p>81. 1000</p> <p>82. 1000</p> <p>83. 1000</p> <p>84. 1000</p> <p>85. 1000</p> <p>86. 1000</p> <p>87. 1000</p> <p>88. 1000</p> <p>89. 1000</p> <p>90. 1000</p> <p>91. 1000</p> <p>92. 1000</p> <p>93. 1000</p> <p>94. 1000</p> <p>95. 1000</p> <p>96. 1000</p> <p>97. 1000</p> <p>98. 1000</p> <p>99. 1000</p> <p>100. 1000</p>																					

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 1803

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		MONTH DAY YEAR	
Earl MOORMAN Hargrove		June 22 1987		3:50 AM	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR	
Male	Black	MONTH DAY YEAR	51 YRS	IF UNDER 24 HRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
Wash., D. C.	USA		Prince George's MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
Clinton	Parkwood Hospital		Locksmith		D.C. School Syst
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE	
Maryland	Prince Geo	Brandywine	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	4909 Accokeek Rd. 20613	
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME		ADDRESS		
Earl Hargrove	Ethel Moorman				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS		
yes	578 46 5616	Mary Hargrove	SAA		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pneumonia</u>					<u>72 hrs</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acquired Immune deficiency Syndrome</u>					<u>6 months</u>
DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
<u>Kaposi's Sarcoma</u>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
<u>X</u>	<u>X</u>	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
	P.M. 19				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>16 June 87</u> to <u>22 June 87</u> , that (I) (we) last saw the deceased alive on <u>22 June 87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED		
<u>Venkat Mani M.D.</u>			<u>16/22/87</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS				
<u>VENKAT MANI M.D.</u>	<u>8126 Woodland Rd #503 CLINTON MD 20735</u>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE		
Burial	25 June 87	Resurrection Cem	Clinton, P.G., Md		
24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE			
<u>Martell Adams</u>	<u>Aguasco Md 20608</u>	<u>JUN 26 1987</u> <u>Julia Finkler-Randall</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

BP



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87

18032

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR		
WILLIAM HARMEL			06 13 87			10:15PM		
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (IN YEARS LAST BIRTHDAY)			7 IF UNDER 1 YEAR		
Male	White	Oct. 16, 1896	90 YRS.			IF UNDER 24 HRS.		
8a BIRTHPLACE (STATE OR FOREIGN COUNTRY)	8b CITIZEN OF WHAT COUNTRY?	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH					
New York	U.S.A.		PRINCE GEORGES COUNTY MD.					
10 CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY	
CHEVERLY	PRINCE GEORGES HOSPITAL CENTER			Tobacco Farmer			Own Farm	
13a STATE			13b COUNTY			13c CITY OR TOWN		
Md.			Anne Arundel			Davidsonville		
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME			16a WAS DECEASED EVER IN U.S. ARMED FORCES?		
Gustav Harmel			Julia (Unknown)			16b SOCIAL SECURITY NO.		
17 INFORMANT			18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))					
Elizabeth Harmel-Davidsonville, Md. 21035			PART 1. DEATH WAS CAUSED BY					
			IMMEDIATE CAUSE (a) ACUTE RESPIRATORY ARREST					
			DUE TO, OR AS A CONSEQUENCE OF					
			Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					
			(b) ACUTE CEREBROVASCULAR ACCIDENT					
			DUE TO, OR AS A CONSEQUENCE OF					
			(c) —					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1								
AORTIC STENOSIS								
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
			HOUR A.M. MONTH DAY YEAR					
			P.M. 19					
21d INJURY OCCURRED			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION		
WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>						STREET CITY OR TOWN COUNTY STATE		
22a I certify that (1) (this hospital) attended the deceased from 6-11 19 87, to 6-13 19 87, and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.								
22b SIGNATURE			DEGREE			22c DATE SIGNED		
Michael York			M.D.			6-14-87		
22d PHYSICIAN'S NAME (TYPE OR PRINT)			22e ADDRESS					
MICHAEL YORK, M.D.			5506 GREEN LANDING RD. UPPER MARLBORO MD. 20772					
23a BURIAL, CREMATION, REMOVAL (SPECIFY)			23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION	
Burial			6/17/87		Mt. Oak Cemetery		Mitchellville (Pr. Geo's) Md.	
24 FUNERAL DIRECTOR			25a DATE REC'D. BY REGISTRAR			25b REGISTRAR'S SIGNATURE		
Richard A. Coleman Funeral Home: Upper Marlboro, Maryland 20772			JUN 22 1987			John Anderson-Randall		

PROCEEDINGS OF THE BOARD

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED
DATE 10/15/01 BY 60322 UCBAW/STP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked "X", item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 87 18033	
1- FOR STATE REGISTRAR 1 DECEASED NAME (TYPE OR PRINT) FIRST JOE MIDDLE HARPER JR. LAST HARPER JR.						2a DATE OF DEATH MONTH DAY YEAR JUNE 26 1987		2b HOUR 3:15AM			
3 SEX Male		4 RACE Black		5 DATE OF BIRTH MONTH DAY YEAR January 24, 1912		6 AGE (IN YEARS LAST BIRTHDAY) 75 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina		7b CITIZEN OF WHAT COUNTRY? United States		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES MD					
10 CITY OR TOWN OF DEATH CLINTON		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SO. MARYLAND HOSPITAL						12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired/Laborer		12b KIND OF BUSINESS OR INDUSTRY Cox Trailer	
13a STATE Maryland		13b COUNTY P. G.		13c CITY OR TOWN Capitol Heights		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 1716 Dewitt Avenue (20743)			
14 FATHER'S NAME FIRST Joe MIDDLE Van LAST Harper				15 MOTHER'S MAIDEN NAME FIRST Martha MIDDLE Jackson LAST							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b SOCIAL SECURITY NO. 237-30-0173		17 INFORMANT 1716 Dewitt Avenue, Capitol Heights, Md. Brenda K. Harper (daughter)					
18 CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorespiratory Arrest										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Cerebral Metastasis											
DUE TO, OR AS A CONSEQUENCE OF (c) Carcinoma of the Lung										4 mo.	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE IMMEDIATE DISEASE OR CONDITION GIVEN IN PART I Chronic Obstructive Pulmonary Disease, Dehydration											
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED				19c AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		19d IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				20c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART II)			
21a INJURY OCCURRED INJURY <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21b PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21c LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from 6/26/87 to 6/26/87 that (I/we) last saw the deceased alive on 6/26/87 and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I/we) did (did not) view the body after death.											
22b SIGNATURE (Signature) DEGREE						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c DATE SIGNED 6/26/87		
22d PHYSICIAN'S NAME (TYPE OR PRINT) KELVIN L. MINCHIN MD						22e ADDRESS 6188 OXON HILL RD OXON HILL MD					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b DATE 07/03/87		23c NAME OF CEMETERY OR CREMATORY Red Hill Cemetery			23d LOCATION CITY OR TOWN COUNTY STATE North Greene County, Carolina		
24 FUNERAL DIRECTOR NAME Latney's Funeral Home, Wash. DC & Norcott & Co. Funeral Home, Ayden, N.C.						25a DATE REC'D. BY REGISTRAR JUL 7 1987					

100 3 2003

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8718034
REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
Bessie Reitha Harris		06 15 87		11 ²⁰ AM	
3 SEX	4 RACE	5. DATE OF BIRTH	6. AGE	7. BALTIMORE CITY OR COUNTY OF DEATH	
Female	Caucasian	July 7, 1891	95 YRS	Prince George's MD.	
8a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	8b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		
Virginia	USA		Practical Nurse		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12b. KIND OF BUSINESS OR INDUSTRY			
Adelphi	Presidential Woods Nursing Home				
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE	
Maryland	Howard	Columbia	YES <input type="checkbox"/> NO <input type="checkbox"/>	10059 Quantrell Road 21046	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME			
William Roberts		Elizabeth Vowell			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		579-48-7995		Catherine M. Eggers Niece Same as 13	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c):					
PART I. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) Cordice Arrest					
DUE TO, OR AS A CONSEQUENCE OF					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
DUE TO, OR AS A CONSEQUENCE OF					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (c)					
Organic Brain Syndrome Dehydration					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
N/A		N/A		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
		HOUR A.M. MONTH DAY YEAR		N/A	
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 2/15/87 to 6/10/87, that (I) (we) lost saw the deceased alive on 6/10/87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
Don H. Yablonsky		MD		6/10/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
Don H. Yablonsky		10300 Greenbelt Rd, Jessbrook, Md 20706			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		Jun. 18, 1987		Graham Cemetery	
24. FUNERAL DIRECTOR (NAME)		23d. LOCATION		23e. COUNTY	
Francis J. Collins, Jr.		Orange		Orange Virginia	
500 University Blvd., W. Silver Spring, Md. 20901		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
		JUN 18 1987		[Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the funeral director with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

CUTTING TIME

1 2 3 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. This permit removes carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene for statistical examination, or removal.

IMPORTANT: If item 21 is marked as item 18, any other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 18035

1. FOR STATE REGISTRAR		REG. NO.	
1 DECEASED NAME (TYPE OR PRINT)		2a DATE OF DEATH MONTH DAY YEAR	
James Richard Harris		June 18, 1987	
3 SEX	4 RACE	5 DATE OF BIRTH MONTH DAY YEAR	6 AGE (IN YEARS LAST BIRTHDAY)
Male	Caucasian	Sept. 27, 1946	40 YRS
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH
Washington, D.C.	U.S.A.		Prince Georges MD.
10 CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b KIND OF BUSINESS OR INDUSTRY
Clinton	6416 Brooke Jane Drive	Bell Captain	Motel
13a STATE	13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
Maryland	Pr. Georges	Clinton	
14 FATHER'S NAME FIRST MIDDLE LAST	15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST	13e STREET ADDRESS / ZIP CODE	
James Buell Harris	Frances Davis	6416 Brooke Jane Drive 20735	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)	17 INFORMANT ADDRESS	
Yes	1966-1968 213-44-4327	Frances Davis Same as 13 a-e.	
18 CAUSE OF DEATH (Enter only one cause per line for a, b, and c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Malnutrition, malnourished with cerebral and brain atrophy</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u>			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)			
19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)	21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from <u>5-22</u> 19 <u>87</u> to <u>5-29</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>5-22</u> 19 <u>87</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.			
22b SIGNATURE	DEGREE	22c DATE SIGNED	
	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	June 19, 1987	
22d PHYSICIAN'S NAME (TYPE OR PRINT)	22e ADDRESS		
Kai-Yiu Yeung	8926 Woodyard Rd. Clinton, Maryland 20735		
23a BURIAL, CREMATION, REMOVAL (SPECIFY)	23b DATE	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION CITY OR TOWN COUNTY STATE
Burial	June 22, 1987	Md. Veteran Cemetery	Cheltenham P.G. Md.
24 FUNERAL DIRECTOR NAME	25a DATE REC'D. BY REGISTRAR	25b REGISTRAR'S SIGNATURE	
Lee Funeral Home, Inc. 6633 Old Alexander Ferry Rd. Clinton, Md.	JUN 24 1987		

BP _____

10/12

10/12



10/12



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 18030

REG. NO.

1- FOR
STATE
REGISTRAR

2 DECEASED NAME (TYPE OR PRINT) Steve Hayas			2a DATE OF DEATH MONTH DAY YEAR June 14, 1987			2b HOUR 1:48 PM			
3 SEX Male		4 RACE white		5 DATE OF BIRTH MONTH DAY YEAR 8 11 98		6 AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN. 88			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Czechoslovakia		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD.			
10 CITY OR TOWN OF DEATH Clinton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Prince Georges Manor		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Coal Miner		12b KIND OF BUSINESS OR INDUSTRY Steel Corp.			
13a STATE Maryland		13b COUNTY Prince George		13c CITY OR TOWN Temple Hills		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14 FATHER'S NAME FIRST MIDDLE LAST George Hayas		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Tupá		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b SOCIAL SECURITY NO. 193-01-3129		17 INFORMANT Margaret Imrich	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio respiratory Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Bilateral Pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) 3 days		PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Alzheimer Dementia Peripheral Vascular Disease		19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR 6/14 87		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)		22a IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		22b DATE SIGNED 6/14/87	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK		21e PLACE OF INJURY (HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 6/14 87		21f LOCATION STREET CITY OR TOWN COUNTY STATE 6188 Oxon Hill Rd Oxon Hill Md		22c DATE SIGNED 6/14/87		22d PHYSICIAN'S NAME (TYPE OR PRINT) KELVIN L. MINCHIN M.D.	
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 6/17/87		23c NAME OF CEMETERY OR CREMATORY Resurrection Cemetery		23d LOCATION CITY OR TOWN COUNTY STATE Clinton P.G. Maryland		24 FUNERAL DIRECTOR NAME ADDRESS George P. Kalas Funeral Home Oxon Hill, Md.	
25a DATE REC'D. BY REGISTRAR JUN 18 1987		25b REGISTRAR'S SIGNATURE Julia Davidson-Rubenstein		25c DATE SIGNED 6/14/87		25d REGISTRAR'S SIGNATURE Julia Davidson-Rubenstein		25e DATE SIGNED 6/14/87	

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 48 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Page 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8718031
REG. NO.

1- STATE REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Elizabeth F. HENAGHAN

2a DATE OF DEATH MONTH DAY YEAR June 21, 1987

2b HOUR 6:53p.m.

3 SEX Female

4 RACE White

5 DATE OF BIRTH MONTH DAY YEAR February 7, 1894

6 AGE (IN YEARS (LAST BIRTHDAY)) 93 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.

7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York

7b CITIZEN OF WHAT COUNTRY? USA

8 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9 BALTIMORE CITY OR COUNTY OF DEATH Prince-Georges MD

10 CITY OR TOWN OF DEATH Hyattsville

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sacred Heart Home, Inc.

12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker

12b KIND OF BUSINESS OR INDUSTRY Home

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Maryland 13b COUNTY Montgomery 13c CITY OR TOWN Rockville

13d INSIDE CITY LIMITS? YES ☐ NO ☐

13e STREET ADDRESS / ZIP CODE 7803 Breezy Down Terrace 20855

14. FATHER'S NAME FIRST MIDDLE LAST Adam Schmitt

15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maria Friedrick

16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO

16b SOCIAL SECURITY NO. 213-42-9145

17 INFORMANT ADDRESS Mary E. Trundle (daughter) same as 13e

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebrovascular Accident

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Organic Brain Syndrome

19a DATE OF OPERATION N/A

19b CONDITION FOR WHICH OPERATION WAS PERFORMED N/A

20a AUTOPSY? YES ☐ NO ☒

20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19

21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) N/A

21d INJURY OCCURRED WHILE ☐ AT WORK NOT WHILE ☐ AT WORK

21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)

21f LOCATION CITY OR TOWN COUNTY STATE

22a I certify that (I) (this hospital) attended the deceased from 4/11, 1987, to 6/21, 1987, that (if (we) lost sight of the deceased on or after (I) (we) (did) (did not) leave the body after death.

22b SIGNATURE Don H. Yablonsky

DEGREE no

ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐

22c DATE SIGNED 6/21/87

22d PHYSICIAN'S NAME (TYPE OR PRINT) Don H. Yablonsky

22e ADDRESS 10300 Greenbelt Rd., Rockbrook, Md.

23a BURIAL, CREMATION, REMOVAL (SPEC) Cremation

23b DATE 6/22/87

23c NAME OF CEMETERY OR CREMATORY Mt. Comfort Crematory

23d LOCATION Alexandria, Virginia STATE

24 FUNERAL DIRECTOR NAME Tyson Wheeler Funeral Home, Inc. 1331 Rockville Pike, Rockville, Md. 20852

25a DATE REC'D. BY REGISTRAR JUN 26 1987

25b REGISTRAR'S SIGNATURE Julia Seiden-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene. If item 21 is marked day, item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

IMPORTANT: If item 21 is marked day, item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 13038
REG. NO.

1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Bernard I. Henry		2a. DATE OF DEATH MONTH DAY YEAR June 25, 1987		2b. HOUR 7:00 P.	
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR April 29, 1942		6. AGE (IN YEARS LAST BIRTHDAY) 45 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD.	
10. CITY OR TOWN OF DEATH Lanham		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Magnolia Gardens Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Fence mender		12b. KIND OF BUSINESS OR INDUSTRY Blg. & Repair	
13a. STATE Md.		13b. COUNTY P.G.		13c. CITY OR TOWN Mitchellville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST James F. Henry		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret E. Shorter		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No			
16a. SOCIAL SECURITY NO. 215-38-3025		17. INFORMANT 7630 Normandy Rd. Sarah L. Ford-Palmer Park, Md.					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>End Stage Renal Disease</u> (c) <u>Severe Hypertensive</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Cerebral Vascular Accident</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>SEPT 26</u> , 19 <u>86</u> , to <u>JUNE 25</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>June 25</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not move the body after death.							
22b. SIGNATURE 		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 6/26/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GEORGE BONE		22e. ADDRESS 8601 MILKING HWY LANHAM, MD.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE 7/1/87		23c. NAME OF CEMETERY OR CREMATORY HARMONY MEM. PARK		23d. LOCATION CITY OR TOWN COUNTY STATE CANOVER, P.G. MD.	
24. FUNERAL DIRECTOR NAME H. S. WASHINGTON & SONS		ADDRESS 4925 BURNING WOOD AVENUE		25a. DATE REC'D BY REGISTRAR JUL 8 1987		25b. REGISTRAR'S SIGNATURE 	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove pages 1 and 2 and place them in the folder provided with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

70% COLLOIDAL B

58113 JUN 30

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 18039			
1- STATE REGISTRAR													
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CARL Frederick HERRMANN										2a DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR 6 24 87		2b HOUR 10A M	
3 SEX M		4 RACE Can		5 DATE OF BIRTH MONTH DAY YEAR 7 20 06		6 AGE (IN YEARS) (LAST BIRTHDAY) MONTH DAYS HOURS MIN 80 YRS.		IF UNDER 1 YR. MONTH DAYS HOURS MIN		IF UNDER 24 HRS. MONTH DAYS HOURS MIN			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash. DC				7b CITIZEN OF WHAT COUNTRY? USA				8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Prince George County MD			
10 CITY OR TOWN OF DEATH Hyattsville				11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 8208 17th place				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) bank teller		12b KIND OF BUSINESS OR INDUSTRY private			
13a STATE MD				13b COUNTY Prince George				13c CITY OR TOWN Hyattsville		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
13e STREET ADDRESS 8208 17th place				13f CITY OR TOWN Hyattsville				13g ZIP CODE 20783					
14 FATHER'S NAME FIRST MIDDLE LAST Ferdinand Herrmann				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marie Wein									
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) yes				16b SOCIAL SECURITY NO. WWII 578-14-9549				17 INFORMANT ADDRESS James G. Ronchi 3902 Forrester Rd 20705					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) atherosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes years													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 none													
19a DATE OF OPERATION none				19b CONDITION FOR WHICH OPERATION WAS PERFORMED?						20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) N/A					
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) none				21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE Paul A DeVore MD				TITLE (SPECIFY) Deputy				DATE SIGNED 6-24-87					
EXAMINER'S NAME (TYPE OR PRINT) PAUL A DEVORE MD				ADDRESS 4203 Queensbury Rd Hyattsville MD 20781									
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b DATE 6/26/87		23c NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery				23d LOCATION CITY OR TOWN COUNTY STATE Suitland Prince George Md			
24a NAME OF REGISTRAR Donald W. Borgwardt				24b ADDRESS 4400 Powder Mill Rd Beltsville Md 20705				25a DATE RECD BY REGISTRAR JUN 29 1987		25b REGISTRAR'S SIGNATURE Julia Davidson			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 12 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8718040

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Raymond L. Hicks			2a. DATE OF DEATH MONTH DAY YEAR June 12, 1987			2b. HOUR 11:55 PM			
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR August 28, 1910		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS.		6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Illinois		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County, MD.			
10. CITY OR TOWN OF DEATH Laurel		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Greater Laurel Beltsville Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Director of Budget		12b. KIND OF BUSINESS OR INDUSTRY Manufacturing	
13a. STATE Maryland		13b. CITY OR TOWN Glenn Dale		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET ADDRESS / ZIP CODE 12116 Augusta Drive 20769			
14. FATHER'S NAME FIRST MIDDLE LAST Harl L. Hicks		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Edna Wheelles							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 333-01-7249		17. INFORMANT Carolyn H. Anderson same as #13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>CARDIOGENIC SHOCK</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c) <u>PROBABLE MYOCARDIAL INFARCTION</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>6/12</u> , 19 <u>87</u> , to <u>6/13</u> , 19 <u>87</u> that (I) (we) lost saw the deceased alive on <u>6/12</u> (we) (did) <u>did not</u> view the body after death.									
22b. SIGNATURE <u>Gregory A. Compton MD</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <u>6-13-87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>GREGORY A. COMPTON MD</u>				22e. ADDRESS <u>3317 Cherry Ln Laurel MD 20707</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE June 16, 1987		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria Virginia			
24. FUNERAL DIRECTOR Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Ave. Bethesda, Maryland 20814						25a. DATE REC'D. BY REGISTRAR JUN 18 1987		25b. REGISTRAR'S SIGNATURE <u>Julia Anderson-Randall</u>	

BP

158057 JUN 3

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

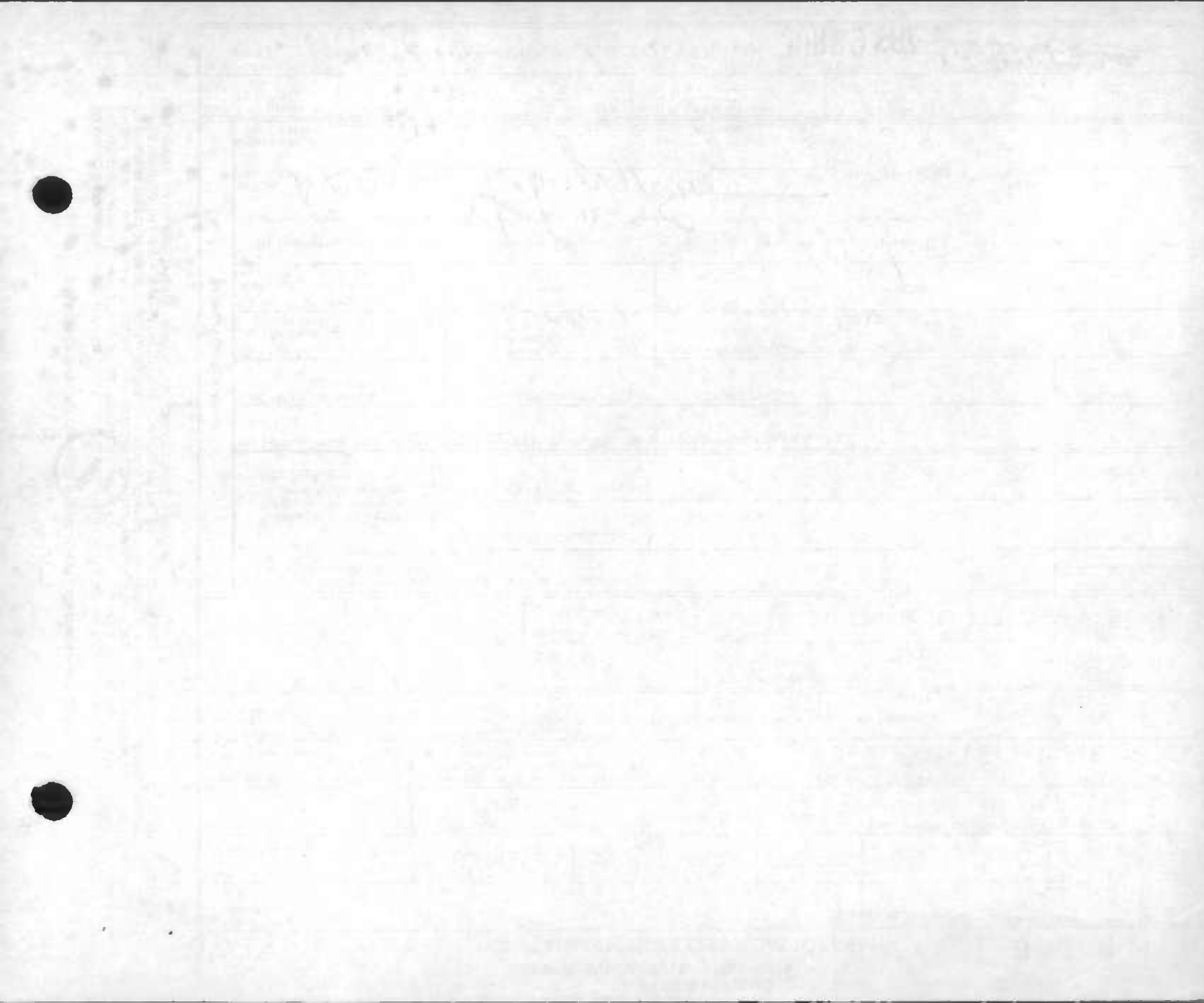
REG NO 18041

1. FOR STATE REGISTRAR		2a. DATE KNOWN OF DEATH		2b. HOUR	
DECEASED NAME (TYPE OR PRINT)		DATE MATED		HOUR	
JOAN Marie HILL		6-26 1987		M	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE	7. IF UNDER 1 YR	7. IF UNDER 24 HRS
Female	White	11-23-1954	32	MONTHS	DAYS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
Wash DC		USA		9. BALTIMORE CITY OR COUNTY OF DEATH	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Cheverly		Prince George's General Hospital		Retail Sales	
12b. KIND OF BUSINESS OR INDUSTRY		13a. STREET ADDRESS		13b. CITY OR TOWN	
Fast Food		20711		Lothian	
13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
Md.		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Patuxent River Rd.	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16. WAS DECEASED EVER IN U.S. ARMED FORCES?	
Philip John Earnest		Joan Marie Kline		No	
16a. SOCIAL SECURITY NO.		17. INFORMANT		17. ADDRESS	
214-66-4986		Philip J. Earnest		Edgewater Md. 857 Selby Blvd.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART 1 DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) Multiple injuries					
DUE TO, OR AS A CONSEQUENCE OF					
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last					
(b) DUE TO, OR AS A CONSEQUENCE OF					
(c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?	
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
		7:26 A.M. 6-26-1987		Driver of auto/truck collision.	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION	
		road		West Central Ave., Davidsonville, Anne Arundel	
22. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE		TITLE/SPECIFY		DATE SIGNED	
Dennis F. Smyth, M.D.		Assistant		6-27-87	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS		111 Penn St., Balto., MD 21201	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		6-30-87		Ft. Lincoln Cem.	
23d. LOCATION		23e. DATE REC'D BY REGISTRAR		23f. SIGNATURE	
Brentwood PG. Md.		JUN 29 1987		Julia Denton-Randall	
24. FUNERAL DIRECTOR NAME		24b. ADDRESS		25a. DATE REC'D BY REGISTRAR	
Hardesty Funeral Home		Annapolis Md.		JUN 29 1987	

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PEN IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER ALONG WITH PAGE 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25MBP
DHMH - 17
(VR A15 ME (5))



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

7 18042

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		3. SEX		4. RACE	
SANG KI HILL		Female		White	
5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. BALTIMORE CITY OR COUNTY OF DEATH	
7-13-1930		56 YRS		Prince George MD	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		9. CITIZEN OF WHAT COUNTRY?		10. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	
Korea		USA		Malcolm Grow Medical Center	
11. CITY OR TOWN OF DEATH		12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		13. KIND OF BUSINESS OR INDUSTRY	
Andrews AFB		Housewife		Household	
14. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		15. CITY OR TOWN		16. INSIDE CITY LIMITS?	
Md. AACo. Odenton		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		17. STREET ADDRESS / ZIP CODE	
18. FATHER'S NAME		19. MOTHER'S MAIDEN NAME		20. SOCIAL SECURITY NO.	
Choe Chil Yol		Oi Chi Hwa		220-66-7288	
21. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		22. INFORMANT		23. ADDRESS	
No		Robert Hill Jr.		Same as #13	
24. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) CARDIAC ARREST					
DUE TO, OR AS A CONSEQUENCE OF (b) SEPSIS					
DUE TO, OR AS A CONSEQUENCE OF (c) UPPER GI BLEED					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: CHRONIC ACTIVE HEPATITIS					
25a. DATE OF OPERATION		25b. CONDITION FOR WHICH OPERATION WAS PERFORMED		26a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
27a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		27b. TIME OF INJURY		27c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
		HOUR A.M. MONTH DAY YEAR			
		P.M. 19			
27d. INJURY OCCURRED		27e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		27f. LOCATION	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				CITY OR TOWN COUNTY STATE	
27g. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 9 JUNE 1987 to 11 JUNE 1987, that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on 11 JUNE 1987, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) (do not) view the body after death.					
27h. SIGNATURE		DEGREE		27i. DATE SIGNED	
Lori J. Heim				11 JUNE 87	
27j. PHYSICIAN'S NAME (TYPE OR PRINT)		27k. ADDRESS		27l. DATE RECEIVED BY REGISTRAR	
LORI J. HEIM, CAPT, USAF, MC		MALCOLM GROW USAF MED CEN AAFB, MD 20331		JUN 16 1987	
28a. BURIAL, CREMATION, REMOVAL (SPECIFY)		28b. DATE		28c. NAME OF CEMETERY OR CREMATORY	
Burial		6-15-87		Md. Veterans Cem.	
28d. LOCATION		28e. NAME OF FUNERAL HOME		28f. DATE RECEIVED BY REGISTRAR	
Crownsville, AAG		Hardesty Funeral Home Annapolis Md		JUN 16 1987	
29. FUNERAL DIRECTOR		30. DATE RECEIVED BY REGISTRAR		31. REGISTRAR'S SIGNATURE	
NAME		ADDRESS			
Hardesty Funeral Home Annapolis Md					

BP



Date		Description		Amount	
1900	Jan 1	Balance		100.00	
1900	Jan 15	Received from John Doe		50.00	
1900	Feb 1	Received from Jane Smith		25.00	
1900	Mar 1	Received from Mr. Brown		75.00	
1900	Apr 1	Received from Mrs. White		30.00	
1900	May 1	Received from Mr. Green		40.00	
1900	Jun 1	Received from Mr. Black		60.00	
1900	Jul 1	Received from Mr. Grey		20.00	
1900	Aug 1	Received from Mr. Blue		15.00	
1900	Sep 1	Received from Mr. Yellow		10.00	
1900	Oct 1	Received from Mr. Purple		5.00	
1900	Nov 1	Received from Mr. Pink		3.00	
1900	Dec 1	Received from Mr. Brown		2.00	
1900	Total			405.00	

057613 JUN 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

18043
REG. NO.

1- FOR STATE REGISTRAR		DECEASED NAME (TYPE OR PRINT)		FIRST John	MIDDLE T.	LAST Hilton	2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 6-18 1987	2b. HOUR 87
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR June 3, 1915	6. AGE (IN YEARS) LAST BIRTHDAY 72 YRS.	IF UNDER 1 YR. MONTHS DAY HOURS MIN.	IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD 6-18 1987	7d. HOUR 87	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's Co. MD		
10. CITY OR TOWN OF DEATH Lanham		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Doctor's Hospital of P.G.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Plumber		12b. KIND OF BUSINESS OR INDUSTRY Plumbing		
13a. STATE Md.		13b. COUNTY P.G. Co.		13c. CITY OR TOWN Temple Hills		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Harry L. Hilton		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST May - Dennison		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes W.W.11				
16b. SOCIAL SECURITY NO. 577-10-8142		17. INFORMANT ADDRESS Sally Toney 6009 Lafayette Ave. Riverdale Md. 20737						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary heart failure DUE TO, OR AS A CONSEQUENCE OF (b) Chronic obstructive pulmonary disease DUE TO, OR AS A CONSEQUENCE OF (c)								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 ? Pancreatic carcinoma, metastatic.								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE Augusto P. Rodriguez		TITLE (SPECIFY) Deputy MEDICAL EXAMINER				DATE SIGNED 6-18-87		
EXAMINER'S NAME (TYPE OR PRINT) Augusto P. Rodriguez, M.D.		ADDRESS 5009 Rayburn Ct., Temple Hills, MD						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6/22/87		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland P.G. Md.		
24. FUNERAL DIRECTOR NAME W.W. Chambers Co. Inc.		ADDRESS Riverdale Md.		25a. DATE RECEIVED BY REGISTRAR 6-24-87		25b. REGISTRAR James R. Rodriguez		

07-84
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(VR A15 ME (5))

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 18044

REG. NO.

1- FOR
STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST WILLIE F. HOLMES			2a. DATE OF DEATH MONTH DAY YEAR 06 02 87			2b. HOUR 10:25A ^M	
3 SEX FEMALE		4 RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR 04 23 27		6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S MD.	
10 CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE'S HOSPITAL CENTER				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Travel Clerk	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY P.G.		13c. CITY OR TOWN Capitol Hgts		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 5705 Rollins Lane 20743	
---	--	--	---------------------	--	-----------------------------------	--	--	--	---	--

14 FATHER'S NAME FIRST MIDDLE LAST Charlie Beecton, Sr.			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie Mae Mills		
---	--	--	---	--	--

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no		16b. SOCIAL SECURITY NO. 239 36 9774		17 INFORMANT Cheryl King-daughter-5707 Rllins Lane	
--	--	---	--	---	--

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Candida - Pulmonary Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Carcinomatosis -</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>lung abscess -</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
---	--	---	--

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. a

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			

22a. I certify that (I) (this hospital) attended the deceased from 4/13 1987 to 6/2 1987, that (I) (we) lost
saw the deceased alive on 6/1 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE <u>Gita K. Shan MD</u>		DEGREE		22c. DATE SIGNED 6-4-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GITA K. SHAN MD		22e. ADDRESS 14333 Laurel Bowie Rd Suit-300 Laurel MD 20708			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE June 8, 1987		23c. NAME OF CEMETERY OR CREMATORY National Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE New Bern, North Carolina	
24. FUNERAL DIRECTOR NAME Stewart Funeral Home-4001 Benning Road N.E.				25a. DATE REC'D BY REGISTRAR JUN 8 1987			

Coroner notified and released

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				87 18045 REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) RAYMOND CLYDE HUDSON				2a. DATE OF DEATH MONTH DAY YEAR June 8, 1987				2b. HOUR 4:00 P.M.	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR September 4, 1904		6. AGE (IN YEARS LAST BIRTHDAY) 82		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD.			
10. CITY OR TOWN OF DEATH Hyattsville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 5620 Hamilton Manor Dr., #1				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Operator		12b. KIND OF BUSINESS OR INDUSTRY U.S. Govt.	
13a. STATE Maryland		13b. COUNTY P.G.		13c. CITY OR TOWN Hyattsville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 5620 Hamilton Manor Dr., #1 20782	
14. FATHER'S NAME FIRST MIDDLE LAST Pierceson M. Hudson		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lara F. Miles		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No					
16b. SOCIAL SECURITY NO. 577-38-8754		17. INFORMANT (Son) 11475 Seaggsville Road Raymond E. Hudson Fulton, Md. 20759							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-respiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Emphysema & Coronary artery disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>4rs</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>immediate</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>1972</u> , 19 <u>87</u> , to <u>Jan</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>Jan</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b. SIGNATURE <u>Robert T. Kelley</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED June 8, 1987			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert Kelley				22e. ADDRESS 8218 Wisconsin Ave., Bethesda, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 06/11/87		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood P.G. Maryland			
24. FUNERAL HOME FRANCIS GASCH'S SONS FUNERAL HOME, PA 4739 Baltimore Ave., Hyattsville, Maryland				25a. FILED BY REGISTRAR JUN 12 1987					

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8718046

REG. NO.

1- FOR
STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Edyth Ruth Husk</i>			2a DATE OF DEATH MONTH DAY YEAR <i>06-23-87</i>			2b HOUR <i>4:10 PM</i>		
3 SEX <i>Female</i>			4 RACE <i>Caucasian</i>			5 DATE OF BIRTH MONTH DAY YEAR <i>07 09 31</i>		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Washington, DC</i>			7b CITIZEN OF WHAT COUNTRY? <i>United States</i>			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
10 CITY OR TOWN OF DEATH <i>Rivendale</i>			11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Beland Memorial Hospital</i>			9 BALTIMORE CITY OR COUNTY OF DEATH <i>Prince Georges</i> MD.		
12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Receptionist</i>			12b KIND OF BUSINESS OR INDUSTRY <i>Doctor</i>					
13a STATE <i>Maryland</i>			13b COUNTY <i>Prince Geo.</i>			13c CITY OR TOWN <i>Brentwood</i>		
14 FATHER'S NAME FIRST MIDDLE LAST <i>Felix P. Denis</i>			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Violet Noldy</i>			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>No</i>			16b SOCIAL SECURITY NO. <i>578-40-5245</i>			17 INFORMANT ADDRESS <i>Everett G. Husk (Husband) Same as #13</i>		
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Large Cell lung cancer</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: c <i>Seizures</i>								
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 <i>87</i>			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 8B PART I OR PART 2)		
21d INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE		
22a I certify that (I) this hospital attended the deceased from <i>6/23</i> 19 <i>87</i> and that in my (our) opinion death occurred on the date and hour and from the causes stated above (II) we (did) (did not) view the body after death								
22b SIGNATURE <i>[Signature]</i>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED <i>6/24/87</i>
22d PHYSICIAN'S NAME (TYPE OR PRINT) <i>Robert Bocca</i>						22e ADDRESS <i>14800 Physicians Ln #232 Rockville</i>		
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>			23b DATE <i>06/26/87</i>			23c NAME OF CEMETERY OR CREMATORY <i>Ft. Lincoln Cemetery</i>		
23d LOCATION CITY OR TOWN COUNTY STATE <i>Brentwood Prince Geo. MD</i>			25a DATE REC'D. BY REGISTRAR			25b REGISTRAR'S SIGNATURE <i>[Signature]</i>		
24 FUNERAL DIRECTOR NAME ADDRESS <i>Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Ave. Hyattsville, MD 20781</i>								

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be filed within 72 hours after death. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death.

20% COTTON FIBER

REG. NO.

14. FATHER'S NAME William J. Bateman		15. MOTHER'S MAIDEN NAME Jenni Concannon	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)	17. INFORMANT ADDRESS 5 Challedon Court Barbara Sillex (Daughter) Walkersville, Md.	
No	218-38-8292		

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular tachycardia.</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2179
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	DUE TO, OR AS A CONSEQUENCE OF: (b) <u>acute Respiratory distress, CHF.</u> DUE TO, OR AS A CONSEQUENCE OF: (c) <u>Chronic obstructive lung disease</u>	

CERTIFICATION	PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a:			
	Renal failure. Dehydration.			
	19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY?	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
	NO	NO	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>

MEDICAL CERTIFICATE	21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>N/A</i> 19	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) <i>N/A</i>		
	21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f LOCATION STREET <i>N/A</i>	CITY OR TOWN	COUNTY STATE

22a I certify that I (this hospital) attended the deceased from 6-19-, 1987, to 6-20 1987 that I (we) lost
saw the deceased alive on 6-19- 1987 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, I (we) (did) (did not) view the body after death.

22b SIGNATURE 	DEGREE	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c DATE SIGNED JUNE-20-87
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22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
RAMAN. R. TULI MD	3601 Taylor Street, Brentwood, Maryland 2072

23a BURIAL, CREMATION, REMOVAL (SPECIFY)	23b DATE	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION CITY OR TOWN	COUNTY	STATE
Burial	06/24/87	George Washington Cem.	Brentwood	P.G.	Maryland

Francis Gasch's Sons Funeral Home, P.A.
4739 Baltimore Avenue Hyattsville, Md. 20781

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the official physician and completely filled out, it should be attached to the death certificate and completely filled out by the funeral director. page 3
should be detached for use as the burial-transit permit. Then please remove the pages from the certificate. Pages 1 and 2 should be filed within 72 hours after death
with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other treatment. **IMPORTANT:** If item 21 is marked on item 18, shows any injury, or other trauma, the medical examiner must be notified. **page 4**

medical examine

MEDICAL CERTIFICATION

BP_____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					87 18048 REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST EDWARD C. JACKSON					2a. DATE OF DEATH MONTH DAY YEAR 06 03 87 2b. HOUR 3:59A _M				
3. SEX MALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR AUGUST 28, 1917		6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S MD			
10. CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE'S HOSPITAL CENTER				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Custodian		12b. KIND OF BUSINESS OR INDUSTRY School	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN Wash., D.C.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 5330 Ames St., N.E. 9299	
14. FATHER'S NAME FIRST MIDDLE LAST EDWARD JACKSON					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ETHEL CLIFTON				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 577 09 8433		17. INFORMANT ADDRESS Patricia Anthony-Daughter-4333 Will Street					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RESPIRATORY FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>METASTATIC COLON CANCER</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>PNEUMONIA</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>6/27</u> 19 <u>87</u> , to <u>6/3</u> 19 <u>87</u> that (I) (we) last saw the deceased alive on <u>6/27</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE K. SUDHAKAR, M.D.					DEGREE M.D.		22c. DATE SIGNED 6/3/87		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) K. SUDHAKAR					22e. ADDRESS 7676 NEW HAMPSHIRE AVE LANGLEY PARK, MD 20783 #212				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6/8/87		23c. NAME OF CEMETERY OR CREMATORY LINCOLN MEMORIAL CEM.		23d. LOCATION CITY OR TOWN COUNTY STATE SUITLAND, MARYLAND			
24. FUNERAL DIRECTOR NAME ALEXANDER S. POPE-2617 Pa Ave SE Wash DC					25a. DATE REC'D. BY REGISTRAR JUN 9 1987				
					25b. REGISTRAR'S SIGNATURE Julia...				

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DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE RECEIVED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 8049	
1- STATE REGISTRAR per FH SB											
1 DECEASED NAME (TYPE OR PRINT) Mary Louise Jackson						2a DATE KNOWN OF DEATH MONTH DAY YEAR 6-22 1987				2b HOUR 8:30 AM	
3 SEX Female		4 RACE BLACK		5 DATE OF BIRTH MONTH DAY YEAR JUNE 24 30		6 AGE (IN YEARS) (LAST BIRTHDAY) 57 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c DATE PRONOUNCED DEAD MONTH DAY YEAR 6-22 1987	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASH D.C.		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH P.G.				MD.	
10 CITY OR TOWN OF DEATH UPPER MARLBORO		11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 16306 Marlboro Pike				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b KIND OF BUSINESS OR INDUSTRY NONE			
13a STATE MD.		13b COUNTY P.G.		13c CITY OR TOWN UPPER MARLBORO		13d INSIDE CITY LIMITS? YES NO <input type="checkbox"/>		13e STREET ADDRESS 16506 MARLBORO PIKE 20772			
14 FATHER'S NAME JAMES				MIDDLE BRENT		15 MOTHER'S MAIDEN NAME LOUISE				LAST PAYTON	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO				16b SOCIAL SECURITY NO. 212-66-7606		17 INFORMANT JOHN JACKSON		ADDRESS 16506 MARLBORO PIKE UPPER MARLBORO MD.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cancer of the Throat DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE FATAL DISEASE OR CONDITION GIVEN IN PART I: _____											
MEDICAL CERTIFICATION											
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE Augusto P. Rodriguez				TITLE (SPECIFY) Deputy				DATE SIGNED 6-22-87			
EXAMINER'S NAME (TYPE OR PRINT) Augusto P. Rodriguez, M.D.				ADDRESS 5009 Rayburn Ct, Temple Hills, MD							
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b DATE 6-27-87		23c NAME OF CEMETERY OR CREMATORY ROLLINS FUNERAL HOME INC. HATHORNY CEMETERY		23d LOCATION CITY OR TOWN COUNTY STATE LANDOVER P.G. MD.			
24 FUNERAL DIRECTOR NAME 4339 HUNT PLACE, N.E. WASHINGTON, D.C. 20019				25a DATE REC'D BY REGISTRAR JUN 29 1987				25b REGISTRAR'S SIGNATURE			

07/84
25M

BP

DHMH - 17
(VR A15 ME (15))

RECEIVED BY THE
UNITED STATES DEPARTMENT OF THE ARMY
WASHINGTON, D.C. 20315

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Item 11 per phone
FOR
1- STATE 6/11/87 DAD
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 18050

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Pearl Victoria Jackson			2a. DATE OF DEATH MONTH DAY YEAR 6-4-87 12 30 54 6:30 PM	
3. SEX F	4. RACE B	5. DATE OF BIRTH MONTH DAY YEAR 8 15 1907		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS MONTHS DAYS HOURS MIN
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	9. BALTIMORE CITY OR COUNTY OF DEATH P.G. Co. MD.		
10. CITY OR TOWN OF DEATH Takoma Park	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 603 Elm Ave. Home		12a. USUAL OCCUPATION (GIVE MOST OF WORKING LIFE) Housewife	
12b. RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 12a. STATE md. 12b. COUNTY Montgomery		13c. CITY OR TOWN Takoma Park	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 7700 Blair Rd #104 / 20912
14. FATHER'S NAME FIRST MIDDLE LAST George A Jones		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Frances A Ward		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 220-16-5358	17. INFORMANT ADDRESS Diane Hill, 603 Elm Ave., Takoma PK., md.	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)
PART I. DEATH WAS CAUSED BY:

(IMMEDIATE CAUSE (a))

Cardiopulmonary arrest

DUETO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause, (a), stating the underlying cause last

(b) Metastatic Thyroid Cancer

DUETO, OR AS A CONSEQUENCE OF

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

Other than generalized Cachexia

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (CERTIFY, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 8 AM 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN PART 2)	
21d. INJURY OCCURRED AT HOME <input type="checkbox"/> NOT HOME <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22. I certify that (1) (this hospital) attended the deceased from 4-30-86 19 to 6-4-87 19 that (we) last saw the deceased alive on 4-23-87 19 and that in my opinion death occurred on the date and hour and from the causes stated above. (I (we) did) (did not) view the body after death.					
22a. SIGNATURE Charles L Franklin Jr				22c. DATE SIGNED 6-4-87	
22b. PHYSICIAN'S NAME (TYPE OR PRINT) Charles L Franklin Jr				22d. ADDRESS 11120 New Hampshire Ave Silver Spring Md 20904	

23a. BURIAL, CREMATION, REMOVAL (SURVEY) Burial	23b. DATE June 9, 1987	23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery Brentwood, Maryland	23d. LOCATION CITY OR TOWN COUNTY STATE
24. FUNERAL DIRECTOR (NAME) John T. Stewart		25a. DATE REC'D. BY REGISTRAR JUN 8 1987	
25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it is to be the funeral director. Page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed - 100000 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 above any injury, or other traumatic event, the medical examiner must be notified.



COTTON CREEP

10/10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the funeral director with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1- FOR STATE REGISTRAR		87		18051		REG. NO.					
1 DECEASED NAME (TYPE OR PRINT) FLORENCE E. JAMES					2a. DATE OF DEATH MONTH DAY YEAR 6-11-87					2b. HOUR 5:30 PM	
3 SEX Female		4 RACE White		5 DATE OF BIRTH Feb. 15, 1898		6 AGE (IN YEARS LAST BIRTHDAY) 89		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Forestville Md		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH PUNCK- GEORGETOWN MD					
10 CITY OR TOWN OF DEATH Clinton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Maryland Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk General		12b. KIND OF BUSINESS OR INDUSTRY Church Conference			
13a. STATE Maryland		13b. COUNTY PR George		13c. CITY OR TOWN Temple Hill		13d. INSIDE CITY LIMITS? NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 3100 Leslie Avenue 20748			
14 FATHER'S NAME FIRST MIDDLE LAST James Bryant				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ida V. Bladen							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 577-01-8602		17 INFORMANT Theresa B James				ADDRESS 3412 Curtis Drive Suitland, Md.			
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c): PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UREMIA DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CHRONIC RENAL INSUFFICIENCY DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 wks. 24 m.											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: ARTERIO-SCLEROTIC HEART DISEASE; CHRONIC CONGESTIVE FAILURE											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 6/10 1987 to 6/11 1987 that (I) (we) lost saw the deceased alive on 6/10 1987 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE J. Sanford Young				DEGREE MD				22c. DATE SIGNED 6/11/87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. Sanford Young				22e. ADDRESS 11701 LIVINGSTON RD. FRESH WASH MD 20744							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 15 June 1987		23c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Arlington VA					
24 FUNERAL DIRECTOR NAME Robert E Wilhelm Funeral Home				ADDRESS Suitland, Md.		25a. DATE REC'D. BY REGISTRAR JUN 15 1987		25b. REGISTRAR'S SIGNATURE Julia			

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1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	100
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58878

-1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 7 1 8 0 5 2

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) CHARLES W. JESS			2a. DATE OF DEATH MONTH DAY YEAR Jun 27, 1987		2b. HOUR 5:18pm
3. SEX Male	4. RACE CAUC	5. DATE OF BIRTH MONTH DAY YEAR DEC 24, 1900		6. AGE (IN YEARS LAST BIRTHDAY) 86y YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD.	
10. CITY OR TOWN OF DEATH Laurel	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Greater Laurel Beltsville Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) bricklayer		12b. KIND OF BUSINESS OR INDUSTRY construction
13a. STATE MD			13b. COUNTY Howard	13c. CITY OR TOWN Jessup	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Edward Howard Jess			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sally Dixon		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no		16b. SOCIAL SECURITY NO. 213-05-8315		17. INFORMANT ADDRESS Maizie Jess Same as above	
18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOVASCULAR COLLAPSE DUE TO, OR AS A CONSEQUENCE OF (b) SEPSIS. DUE TO, OR AS A CONSEQUENCE OF (c) CEREBROVASCULAR Insufficiency Conditions, if any, which gave rise to immediate cause 1a), stating the underlying cause last					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. a 1) Atherosclerotic heart disease 2) peptic ulcer 3) COLICVA.					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 6-18 , 19 87 , to 6-27 , 19 87 , that (I) (we) last saw the deceased alive on 6-27 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Gursewa S. Parla M.D.				22c. DATE SIGNED 6-27-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GURSEWA S. PARLA M.D.				22e. ADDRESS 8381 CHERRY LANE, LAUREL, MD 20707	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE June 30, 1987		23c. NAME OF CEMETERY OR CREMATORY Meadowridge Mem. Park	
24. FUNERAL DIRECTOR (NAME) Donaldson Funeral Home		24b. ADDRESS Laurel, Md. 20707		25a. DATE REC'D. BY REGISTRAR 1001 06 1987	
25b. REGISTRAR'S SIGNATURE				25c. REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 3 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1- FOR STATE REGISTRAR		7 18053									
1 DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a DATE OF DEATH MONTH DAY YEAR		2b HOUR	
Bessie P. JOHNSON								June 7 1987		7:25am	
3 SEX		4 RACE		5. DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
Female		Black		Dec. 26, 1900		86					
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH					
Md.		U.S.A.				Prince George's MD					
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY					
Lanham		AMI Doctors Hospital of P.G. Co.		Clerk - Insurance Co.							
13a STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE			
Md.		P.G.		Lanham				9301 Good Luck Rd. 20706			
14 FATHER'S NAME FIRST MIDDLE LAST				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
Franklin Pierce				Adeline Starr							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO.		17 INFORMANT ADDRESS							
No		213-16-5590		Lawrence Chittams- Lanham, Md.							
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <u>CARDIO PULMONARY ARREST</u>										MINUTES	
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.											
(b) <u>MASSIVE INTRACEREBRAL BLEED</u>										DAYS	
DUE TO, OR AS A CONSEQUENCE OF											
(c) <u>ARTERIOVENOUS MALFORMATION</u>										YEARS	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1											
<u>ESSENTIAL HYPERTENSION</u>											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
		P.M. 19									
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a I certify that (I) (this hospital) attended the deceased from <u>DEC 26, 1986</u> to <u>JUNE 7, 1987</u> that (I) (we) last saw the deceased alive on <u>6-7-87</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE				DEGREE				22c DATE SIGNED			
<u>G. BONE</u>								6/9/87			
22d PHYSICIAN'S NAME (TYPE OR PRINT)				22e ADDRESS							
<u>G. BONE</u>				<u>8101 M.L. KING SA. HWY LANHAM</u>							
23a BURIAL, CREMATION, REMOVAL		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION CITY OR TOWN COUNTY STATE					
		6/12/87		HARMONY MEM. PARK		LANHAM, P.G. MD.					
24 FUNERAL DIRECTOR NAME				ADDRESS				25a DATE REC'D. BY REGISTRAR		25b REGISTRAR'S SIGNATURE	
<u>H.S. WASHINGTON & SONS</u>				<u>4925 BURNING WOOD AVE N.C.</u>				<u>JUN 18 1987</u>		<u>Julia Swanson-Randall</u>	

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 18054	
1- STATE REGISTRAR FOR DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CARY L. JOHNSON										2a DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR 6-13-87 19	
3 SEX Male	4 RACE Black	5 DATE OF BIRTH MONTH DAY YEAR 7 18 53	6 AGE IN YEARS (LAST BIRTHDAY) 33 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS.	2c DATE PRONOUNCED DEAD 6-13-87 19		2d HOUR 6:03 PM			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.C.		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD					
10 CITY OR TOWN OF DEATH Seat Pleasant		11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Antelope Lane off Eastern Avenue				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) N/A		12b KIND OF BUSINESS OR INDUSTRY			
13a STATE N.C.		13b CITY OR TOWN Fayetteville		13c STREET ADDRESS 1308 Deep Creek Rd.		13d INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					
14 FATHER'S NAME FIRST MIDDLE LAST Eddie Lee Johnson				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mae Lou Whited							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A		17 INFORMANT ADDRESS Mae Johnson 1308 Deep Creek Rd.							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Narcotic intoxication DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1											
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? P.M. 6-?-87 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject used drugs					
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>				21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) street		21f LOCATION STREET CITY OR TOWN COUNTY STATE Antelope Lane off Eastern Ave Seat Pleasant, Maryland					
22a I certify that I took charge of the remains described above, held in death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE <i>John E. Smialek</i>				TITLE (SPECIFY) M.D. Chief				DATE SIGNED 6-14-87			
EXAMINER'S NAME (TYPE OR PRINT) John E. Smialek, M.D.				ADDRESS 111 Penn Street							
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b DATE 6-20-87		23c NAME OF CEMETERY OR CREMATORY Good Hope		23d LOCATION CITY OR TOWN COUNTY STATE Fayetteville, N.C.			
24 FUNERAL DIRECTOR NAME ADDRESS March Funeral Home 1101 E. North Ave						25a DATE REC'D. BY REGISTRAR JUN 16 1987		25b REGISTRAR'S SIGNATURE <i>Julia Seiden-Randall</i>			

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DAIKIN POND



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

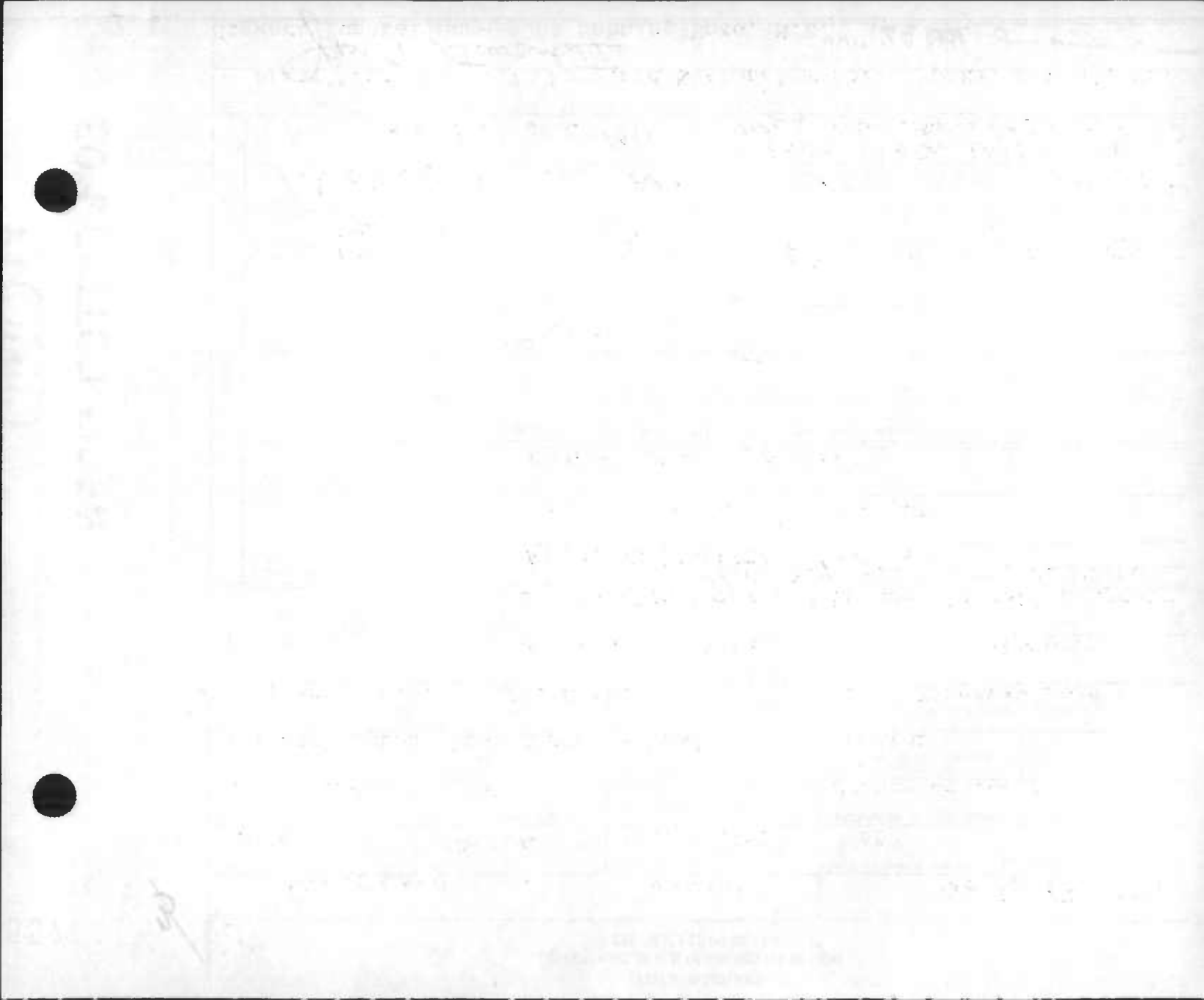
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) CLEVELAND A. JOHNSON		2a. DATE OF DEATH MONTH DAY YEAR 06 16 87		2b. HOUR 9 20 P.M.	
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR Jan. 30, 1922		6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD.	
10. CITY OR TOWN OF DEATH Ft. Washington		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2803 Kingsway Road		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Waiter		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY P.G.		13c. CITY OR TOWN Ft. Wash.		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Johnny Johnson		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Beulah Thompson		13e. STREET ADDRESS / ZIP CODE 2803 Kingsway Road 20744			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 242 14 2128		17. INFORMANT ADDRESS Loretta Johnson-wife-2803 Kingsway Road, Fort Washington, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ACUTE RESPIRATORY ARTERIES DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) LUNG CANCER, METASTATIC DUE TO, OR AS A CONSEQUENCE OF (c) ESOPHAGEAL CANCER							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (his hospital) attended the deceased from 6-15 19 87 to 6-16 19 87 , that (I) (we) last saw the deceased alive on 6-16 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Michael F. York MD		DEGREE MD		ATTENDING MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 6-17-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MICHAEL F. YORK MD		22e. ADDRESS 5506 GREEN LANDING RD. VIVER MARYLAND MD 20772					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE June 20, 1987		23c. NAME OF CEMETERY OR CREMATORY Maryland National Memorial park, Laurel, Md.		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL HOME NAME Stewart Funeral Home-4001 Benning Road, N.E.		25a. DATE REC'D. BY REGISTRAR JUN 24 1987		25b. REGISTRAR'S SIGNATURE John T. Stewart			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

(IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.)

BP _____



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8718056

1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ELSIE MAE JOHNSON			2a. DATE OF DEATH MONTH DAY YEAR 06 11 87		2b. HOUR 3 00 PM
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR 06 09 1929		6. AGE (IN YEARS LAST BIRTHDAY) 58 YRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASH. D.C.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S MD.	
10. CITY OR TOWN OF DEATH CHEVERLY	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE'S HOSPITAL CENTER		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY AT HOME
13a. STATE Md.	13b. COUNTY P.G.C.	13c. CITY OR TOWN LANDOVER	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 3408 63rd AVE. 20784	
14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM E. BAKERSMITH		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY E. JAMES			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 578-40-8637		17. INFORMANT ADDRESS LINDA D. SEATON 7755 GARRISON RD. WEST LANHAM HILLS, Md.	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBROVASCULAR ACCIDENT DUE TO, OR AS A CONSEQUENCE OF (b) SEPTICEMIA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) ACUTE RENAL FAILURE					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) HYPERTENSION DIABETES MELLITUS CORONARY ARTERY DISEASE					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 5:26 to 6:11, 1987 that (I) (we) last saw the deceased alive on 8:11, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE VP SINGH		DEGREE MD		22c. DATE SIGNED 6/28/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) V.P. SINGH		22e. ADDRESS 5622 ANNAPOLIS RD #9 BLADENBORO, MD 2071-9			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 6-15-1987	23c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CEMETERY		23d. LOCATION (CITY OR TOWN COUNTY STATE) BRENTWOOD, P.G.C. Md.	
24. FUNERAL DIRECTOR NAME W. W. CHAMBERS CO.		ADDRESS RIVERDALE, Md. 20737		25a. DATE REC'D BY REGISTRAR JUN 17 1987	
				25b. REGISTRAR'S SIGNATURE Julia Burton-Randall	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8718057	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Hayden E. Jones Sr.						2a. DATE OF DEATH MONTH DAY YEAR 6/5/87		2b. HOUR 8:45 AM			
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Jan. 24, 1935		6. AGE (IN YEARS LAST BIRTHDAY) 52 YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD.					
10. CITY OR TOWN OF DEATH Suitland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4417 Reamy Drive				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Engineer		12b. KIND OF BUSINESS OR INDUSTRY Steam			
13a. STATE Maryland		13b. COUNTY Pr. Georges		13c. CITY OR TOWN Suitland		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 4417 Reamy Drive 20746			
14. FATHER'S NAME FIRST MIDDLE LAST Arthur Jones				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Grace Copley							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 233-52-8986		17. INFORMANT ADDRESS Marie A. Jones Same as #13 a-e.							
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>RESPIRATORY / CARDIOVASC ARREST</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>CHRONIC PAIN</u> 6 months (c) <u>METASTATIC COLON CARCINOMA</u> 18 months											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <u>NONE</u>											
19a. DATE OF OPERATION 6/18/86		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED COLON CANCER				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOT BY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) - O -							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>July 22, 1986</u> to <u>MAY 31, 1987</u> that (I) (we) last saw the deceased alive on <u>19</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Everard H. Hughes</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED June 5, 1987			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) EVERARD H. HUGHES				22e. ADDRESS 8300 Corporate Drive Landover, Maryland							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 06/08/87		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland Prince George Md/					
24. FUNERAL DIRECTOR NAME Lee Funeral Home, Inc.				25a. DATE REC'D. BY REGISTRAR JUN 16 1987							
25b. REGISTRAR'S SIGNATURE 6633 Old Alexander Ferry Rd Clinton Md 20735				25c. REGISTRAR'S SIGNATURE Julia Gordon-Landover							

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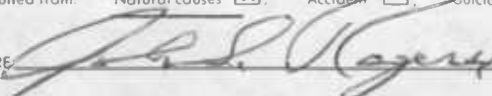
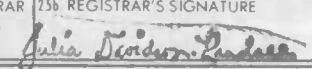
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**STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

REG. NO. **1 8 0 5 8**

FOR
STATE
REGISTRAR

1- DECEASED NAME (TYPE OR PRINT) Howard Jones, Sr.				2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> 6/12 19 87				7b. HOUR M	
3 SEX Male		4 RACE Black		5. DATE OF BIRTH MONTH DAY YEAR Sep. 22, 1917		6 AGE (IN YEARS) LAST BIRTHDAY YRS. 69		IF UNDER 1 YR MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia				7b. CITIZEN OF WHAT COUNTRY? USA				8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Painter				12b. KIND OF BUSINESS OR INDUSTRY Private	
11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 8160 Mandan Drive				12c. DATE PRONOUNCED DEAD 6/12 19 87				2d. HOUR 5:30 P. M.	
13a. STATE Maryland				13b. COUNTY Prince George's				13c. CITY OR TOWN Greenbelt	
13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				13e. STREET ADDRESS 8160 Mandan Drive				20770	
14. FATHER'S NAME FIRST MIDDLE LAST Henry Jones				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Eula Hunt					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 226-14-7194				17. INFORMANT ADDRESS Lucy Jones/8160 Mandan Terr/Greenbelt, Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic carcinoma DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) carcinoma of the throat. DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 None									
19a. DATE OF OPERATION None				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) None			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .									
ACTUAL SIGNATURE 				TITLE (SPECIFY) Deputy MEDICAL EXAMINER				DATE SIGNED 6/13/87	
EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers, M.D.				ADDRESS 1919 Seminary Road Silver Spring, Montgomery County, MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE Jun 17 1987		23c. NAME OF CEMETERY OR CREMATORY Maryland National		23d. LOCATION CITY OR TOWN COUNTY STATE LAUREL PG MARYLAND	
24. FUNERAL DIRECTOR NAME J.B. Jenkins				FH/7474 Landover Rd/Landover, Md.				25a. DATE REC'D. BY REGISTRAR JUN 15 1987	
				25b. REGISTRAR'S SIGNATURE 					

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORM PW 3. RETAIN PAGES 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 7 1 8 0 5 9

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) LETTY K. JONES			2a. DATE OF DEATH MONTH DAY YEAR 6-23-87		2b. HOUR 1:15^{PM}
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR Jan. 2, 1897		6. AGE (IN YEARS LAST BIRTHDAY) 90	7. IF UNDER 1 YEAR MONTHS DAYS 0 0
7a. BIRTHPLACE (COUNTRY) PA.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE-GEORGES CO. MD.	
10. CITY OR TOWN OF DEATH CLINTON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) So. Maryland Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. STATE Maryland	13b. COUNTY P. G.	13c. CITY OR TOWN Temple Hills	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 2991 Brinkley Road 20748	
14. FATHER'S NAME (TYPE OR PRINT) William McClellan		15. MOTHER'S MAIDEN NAME (TYPE OR PRINT) Elizabeth Yeager		16. ADDRESS 4316 Weldon Dr. Temple Hills, Md 20748	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) N/A		17. INFORMANT Clifford Jones	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Sepsis DUE TO, OR AS A CONSEQUENCE OF (c) Gangrene of Rt lower extremity APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hr. 3 days + two weeks					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Urosepsis, Embolism Rt lower extremity, Diabetes mellitus					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPOST YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from July 19 87 , to June 23 19 87 , that (I) (we) lost saw the deceased alive on June 22 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE David N. Robb		DEGREE M.D.		22c. DATE SIGNED 6-23-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DAVID N ROBB M.D.		22e. ADDRESS 940 Indian Head Hwy Ft Washington Md 20744			
23a. BURIAL, CREMATION, REMOVAL (RECEIVED) Burial		23b. DATE 06/26/87	23c. NAME OF CEMETERY OR CREMATORY Holy Comm. Luth. Ch. Cem		23d. LOCATION CITY OR TOWN COUNTY STATE Yeagerstown PA.
24. FUNERAL DIRECTOR NAME Lee Funeral Home, Inc.			25a. DAY RECEIVED BY REGISTRAR JUN 24 1987		
ADDRESS Old Alexander Ferry Rd Clinton, Md 20735			25b. REGISTRAR'S SIGNATURE Julia Gordon-Randall		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked, item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

057738

TO HOSPITAL OR ATTENDING PHYSICIAN: The low register is for the death certificate to be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been completed, the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The funeral director's copy should be filed with the funeral director, page 3 should be detached for use as the burial-transit permit. The funeral director's copy should be filed with the funeral director, page 3 should be detached for use as the burial-transit permit.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 1/81
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

67 18000

FOR STATE REGISTRAR				REG. NO.			
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Peto W. Jones				2a. DATE OF DEATH MONTH DAY YEAR Feb. 4, 1987			
3 SEX Male		4 RACE Black		5 DATE OF BIRTH MONTH DAY YEAR Feb. 4, 1987		2b. HOUR 12:50 ^P _M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		6 AGE (IN YEARS LAST BIRTHDAY) Newborn YRS	
10 CITY OR TOWN OF DEATH Cheverly		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Prince George's Hospital Center				9 BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD.	
13a. STATE Maryland		13b. COUNTY PG		13c. CITY OR TOWN Capt. Hgts.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST Bryson Wade Jones				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Susan Louise Coleman			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17 INFORMANT ADDRESS			
18 CAUSE OF DEATH (Enter only one cause per line for a, b, and c) PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ASPHYXIA NEONATORUM DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last b) EXTREME PREMATURITY DUE TO, OR AS A CONSEQUENCE OF c) PREMATURE RUPTURE OF MEMBRANE							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 HR 2 HR 6 DAYS
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (b)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 2/4 1987 to 2/4 1987 that (I) (we) lost saw the deceased alive on 2/4 1987 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE STEVEN P. WYNER, MD				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 7/1/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) STEVEN P. WYNER, MD				22e. ADDRESS PRINCE GEORGE'S HOSP., CHEVERLY, MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY Prince George's Hosp.		23d. LOCATION CITY OR TOWN COUNTY STATE Cheverly PG Maryland	
24 FUNERAL DIRECTOR NAME ADDRESS				25a. DATE REC'D. BY REGISTRAR JUL 06 1987			
				25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST EVA M KAYS		2a. DATE OF DEATH MONTH DAY YEAR 6/5/87		2b. HOUR 6:55 P.M.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR August 9 1912	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Canada		7b. CITIZEN OF WHAT COUNTRY? USA		6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. 74 YRS.	
10. CITY OR TOWN OF DEATH Clinton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Maryland Hospital		9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD	
12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 12b. COUNTY Washington DC		12c. CITY OR TOWN Washington DC		12d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
13a. STREET ADDRESS / ZIP CODE 2712 29th St SE #232		13b. STREET ADDRESS / ZIP CODE 99999		13c. STREET ADDRESS / ZIP CODE 99999	
14. FATHER'S NAME FIRST MIDDLE LAST William Howard Dobson		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lila Leach		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No	
16b. SOCIAL SECURITY NO. 215-38-2785		17. INFORMANT Stephen P Burton		ADDRESS 5112 Belgreen St Suitland, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>CEREBROVASCULAR ACCIDENT</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <u>SEPTICEMIA, CONGESTIVE HEART FAILURE</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (I) (this hospital) attended the deceased from 4:30, 19 87, to 6:15, 19 87 that (I) (we) last saw the deceased alive on 6/5, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE <u>SA Walen</u> DEGREE	
22c. DATE SIGNED 6/6/87		22d. PHYSICIAN'S NAME (TYPE OR PRINT) Gurbux H Nachnani		22e. ADDRESS #601 8926 Woodyard Rd Clinton Md 20735	
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE 6-10-87		23c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Arlington VA		24. FUNERAL DIRECTOR NAME Robert E Wilhelm		25a. DATE RECD BY REGISTRAR 25b. REGISTRAR'S SIGNATURE JUN 9 1987 Julia D. Burton	
25c. ADDRESS Funeral Home		25d. ADDRESS Suitland, Md.			

Form with multiple sections and fields, including a header section with a date field, a main body with several rows of data, and a footer section with a date field. The form is partially filled out with handwritten text.

Header section: DATE: [blank] TIME: [blank]

Main body: [Multiple rows of data, some with handwritten entries like "10-1-1941", "10-2-1941", "10-3-1941", "10-4-1941", "10-5-1941", "10-6-1941", "10-7-1941", "10-8-1941", "10-9-1941", "10-10-1941", "10-11-1941", "10-12-1941", "10-13-1941", "10-14-1941", "10-15-1941", "10-16-1941", "10-17-1941", "10-18-1941", "10-19-1941", "10-20-1941", "10-21-1941", "10-22-1941", "10-23-1941", "10-24-1941", "10-25-1941", "10-26-1941", "10-27-1941", "10-28-1941", "10-29-1941", "10-30-1941", "10-31-1941"]

Footer section: DATE: [blank] TIME: [blank]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 18062

REG. NO.

1- FOR STATE REGISTRAR		2a DATE OF DEATH		MONTH DAY YEAR		2b HOUR	
1 DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		6 13 87		135 A M	
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS (LAST BIRTHDAY))	
Male		Caucasian		Sept. 23 1911		75	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH	
Wash. D.C.		U.S.A.				Prince Georges MD	
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY	
Clinton		So. Maryland Hosp Center		Sheetmetal		Cont.	
13a STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?	
Maryland		Charles		Waldorf		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14 FATHER'S NAME		15 MOTHER'S MAIDEN NAME		13e STREET ADDRESS / ZIP CODE			
FIRST MIDDLE LAST		FIRST MIDDLE LAST		930 Copley Ave.-20601			
Miland I. Kidwell		Mary (Unavail.)					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO.		17 INFORMANT		ADDRESS	
No		577-05-3103		Ruth C. Kidwell		(Same as #13)	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
		CARDIORESPIRATORY ARREST					
DUE TO, OR AS A CONSEQUENCE OF		(b) ATHEROSCLEROTIC HEART DISEASE.					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO, OR AS A CONSEQUENCE OF		(c) ACQUIRED IMMUNE DEFICIENCY SYNDROME.			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY?		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18B PART 1 OR PART 2)			
		HOUR A.M. MONTH DAY YEAR					
		P.M. 19					
21d INJURY OCCURRED		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION			
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				STREET CITY OR TOWN COUNTY STATE			
				6/25/87			
22a I certify that (I) (this hospital) attended the deceased from		6/12/87		19		to 6/13/87 19	
saw the deceased alive on		above, (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE		DEGREE		22c DATE SIGNED			
RBSLNY		MD ACC		6.13.87			
22d PHYSICIAN'S NAME (TYPE OR PRINT)		22e ADDRESS					
RAJ. SAMTANI MD FAC		7501 SURREATS RD CLINTON MD					
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION	
Cremation		6/14/87		Huntt Crematory		Waldorf, Charles, Maryland	
24 FUNERAL DIRECTOR		P.O. Box 156		25a DATE REC'D. BY REGISTRAR		25b REGISTRAR'S SIGNATURE	
Huntt Funeral Home		Waldorf, Md 20601		JUN 16 1987		Julia Gordon-Randall	

UNITED STATES DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY
WASHINGTON, D. C. 20250

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers, Pages 1 and 2, and deliver them within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical certificate completed.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87-18063

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Bernice M. King			7a. DATE OF DEATH MONTH DAY YEAR 6 3 87			7b. HOUR 10:00 P.M.			
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR April 21, 1904		6. AGE (IN YEARS LAST BIRTHDAY) 83		8. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George MD.			
10. CITY OR TOWN OF DEATH Clinton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Maryland Hospital Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Chief Operator		12b. KIND OF BUSINESS OR INDUSTRY C & P Telephone	
13a. STATE Maryland		13b. COUNTY Prince George		13c. CITY OR TOWN Temple Hills		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1909 Colebrooke Dr. 20748	
14. FATHER'S NAME FIRST MIDDLE LAST Philip A. Willett				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Adelaide Murray					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 216-16-2378		17. INFORMANT Alma B. Kidwell		ADDRESS 1909 Colebrooke Dr. Temple Hills, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Lung with metastases DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) HCVD; Diabetes Mellitus									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (the doctor) attended the deceased from 2/8/1980 to June 3rd, 1987, that (I) (we) lost saw the deceased alive on June 3rd, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) did not view the body after death.									
22b. SIGNATURE Victor S. Chupkovich, M.D.				DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 6/4/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Victor S. Chupkovich, M.D.				22e. ADDRESS 9131 Piscataway Rd., Clinton, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6/6/87		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland P.G. Maryland			
24. FUNERAL DIRECTOR NAME George P. Kalas Funeral Home				6160 Oxon Hill Rd. Oxon Hill, Md.		25a. DATE REC'D. BY REGISTRAR JUN 9 1987		25b. REGISTRAR'S SIGNATURE Julia Gordon-Randall	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, pages 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO. 18064				
1 DECEASED NAME (TYPE OR PRINT) Bertha G. KING					2a DATE OF DEATH MONTH DAY YEAR June 30, 1987			2b HOUR 2:30p. M	
3 SEX Female		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR February 21, 1904		6 AGE (IN YEARS LAST BIRTHDAY) 83 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) District of Columbia		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Prince-Georges MD.			
10 CITY OR TOWN OF DEATH Hyattsville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sacred Heart Home, Inc.				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
13a STATE Maryland		13b COUNTY Prince-Georges		13c CITY OR TOWN Hyattsville		13e STREET ADDRESS / ZIP CODE 8210 15th Avenue 20783			
14 FATHER'S NAME FIRST MIDDLE LAST Joseph M. Padgett					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary G. Simms				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO					16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 577-54-1710		17 INFORMANT niece Mary G. McKinney ADDRESS 6909 Farragut St. Hyattsville, MD 20784		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 DAYS									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. a CORONARY INSUFFICIENCY									
19a DATE OF OPERATION —		19b CONDITION FOR WHICH OPERATION WAS PERFORMED —			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) —					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE-FARM, ETC.) —		21i. LOCATION STREET CITY OR TOWN COUNTY STATE —					
22a. I certify that (I) (this hospital) attended the deceased from 12/10/86 to 6/30/87 that (I we) last saw the deceased alive on 6/27/87 19 87 , and that in my (her) opinion death occurred on the date and hour and from the causes stated above (I we) (did not) view the body after death.									
22b. SIGNATURE Dennis J. Hand MD					DEGREE MD			22c. DATE SIGNED 6/30/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DENNIS J. HAND					22e. ADDRESS 4600 CONNECTICUT AVE NW WASHINGTON DC 20008				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE July 3, 1987		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland Prince Georges MD			
24. FUNERAL DIRECTOR NAME Francis J. Collins, Jr. 500 University Blvd., W Silver Spring, MD 20901					25a. DATE REC'D. BY REGISTRAR JUL 8 1987		25b. REGISTRAR'S SIGNATURE John F. ...		

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<p>10/15/12</p>	<p>10/15/12</p>	<p>10/15/12</p>	<p>10/15/12</p>
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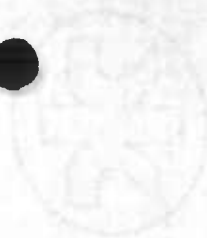
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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Thomas Bryan Kinnaman					2a. DATE OF DEATH MONTH DAY YEAR 6-24-87				
3 SEX Male		4 RACE Caucasian		5 DATE OF BIRTH MONTH DAY YEAR 10 07 1896		6 AGE (IN YEARS LAST BIRTHDAY) 90 YRS.		2b. HOUR 1230 P ^M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD.			
10 CITY OR TOWN OF DEATH Clinton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Pineview Nursing Home			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer		12b. KIND OF BUSINESS OR INDUSTRY Agriculture		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Pr. Georges 13c. CITY OR TOWN Waldorf					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 15101 Gardiner Road/20601		
14 FATHER'S NAME FIRST MIDDLE LAST Thomas Edward Kinnaman					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Ellen Carroll				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) ---		17 INFORMANT ADDRESS James B. Kinnaman - same as # 13					
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sepsis</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Generalized Atherosclerosis</u> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 <u>atrial fibrillation, Cerebrovascular Accident, Diabetes Mellitus</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (the hospital) attended the deceased from <u>7-11-79</u> , 19 <u>87</u> , to <u>6-24</u> , 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>6-14-</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b. SIGNATURE <u>R.A. McConaughy MD</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>6-24-87</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) R.A. McConaughy, MD.				22e. ADDRESS 5618 St. Barnabas Rd. Oxon Hill, MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6-27-87		23c. NAME OF CEMETERY OR CREMATORY Christ Episcopal		23d. LOCATION CITY OR TOWN COUNTY STATE Accokeek Pr. Geo. Md.			
24. FUNERAL DIRECTOR NAME Hunt Funeral Home				ADDRESS P. O. Box 156 Waldorf, Md. 20601		25a. DATE RECD. BY REGISTRAR JUN 26 1987		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The following information is required for the death certificate to be filed with the State Department of Health and Mental Hygiene. The information should be filed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, page 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 1/81
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 87 18060

1. FOR STATE REGISTRAR		20. DATE OF DEATH		21. DATE OF DEATH	
1. DECEASED NAME		20. DATE OF DEATH		21. DATE OF DEATH	
Joseph Benton Kirby, Sr.		6 2 87		4 38 A M	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE	7. BALTIMORE CITY OR COUNTY OF DEATH	
M Male	W Caucasian	7 15 12	74	PRINCE GEORGES CO MD	
7a. BIRTHPLACE	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED	9. BALTIMORE CITY OR COUNTY OF DEATH	10. CITY OR TOWN OF DEATH	
Washington, D.C.	U.S.A.	NEVER MARRIED	PRINCE GEORGES CO MD	Clinton	
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION	12a. USUAL OCCUPATION	12b. KIND OF BUSINESS OR INDUSTRY	13. STREET ADDRESS	
Clinton	So. Maryland Hospital	meat cutter	grocery store	5917 Surratts Village Drive	
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME	16a. WAS DECEASED EVER IN U.S. ARMED FORCES?	16b. SOCIAL SECURITY NO.	17. INFORMANT (son)	18. ADDRESS
Joseph H. Kirby	Marylee Williams	yes	578-07-0850	Joseph B. Kirby, Jr	same as 13 a - e
19. CAUSE OF DEATH					
PART 1. DEATH WAS CAUSED BY					
888 IMMEDIATE CAUSE (a) Pneumonia					
DUE TO, OR AS A CONSEQUENCE OF					
(b) Aspiration					
DUE TO, OR AS A CONSEQUENCE OF					
(c) Alzheimer's Disease					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:					
Pseudomonas Bacteremia					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	21. HOW INJURY OCCURRED	
5/11/87	recurrent aspiration	YES	YES	Aspirated bolus of food, lost consciousness	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH	21b. TIME OF INJURY	21c. HOW INJURY OCCURRED	21d. PLACE OF INJURY		
YES	4 26 87	fell and fractured nose.	at home		
21e. INJURY OCCURRED	21f. LOCATION	21g. CITY OR TOWN			
at home	5917 Surratts Village Dr.	Clinton Md P. G.			
22. I certify that (I) [this hospital] attended the deceased from 4/28/87 to 6/2/87 that (I) (we) last saw the deceased alive on 6/2/87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated					
22a. SIGNATURE	22b. PHYSICIAN'S NAME	22c. DATE SIGNED	22d. ADDRESS		
Oswald L. Hays MD	Oswald L. Hays	6/2/87	9131 Piscataway Rd Clinton Md		
23a. BURIAL, CREMATION, REMOVAL	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION	23e. DATE REC'D. BY REGISTRAR	
Burial	June 5, 1987	Cedar Hill Cemetery	Suitland, Prince Georges' MD	JUN 5 1987	
24. FUNERAL DIRECTOR	24b. ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE	25c. DATE REC'D. BY REGISTRAR	
Lee Funeral Home, Inc.	Old Alexander Ferry Rd., Clinton, MD 20735	JUN 5 1987	Julia S. S. S. S.	JUN 5 1987	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a reasonable length. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and a copy filed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

DHMH - 16 50M 1/B1
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) VELARIA S. KITTRIDGE			2a DATE OF DEATH MONTH DAY YEAR 6-5-87			2b HOUR 2:00 PM			
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR May 6, 1906		6 AGE (IN YEARS LAST BIRTHDAY) 81 YRS		7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Thurmond West VA.		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Prince Georges Co MD			
10 CITY OR TOWN OF DEATH CLINTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SO. Maryland Hospital				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b KIND OF BUSINESS OR INDUSTRY Own Home	
13a STATE Maryland		13b COUNTY Pr Geo		13c CITY OR TOWN Suitland		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS 4818 Eastern Lane 20746	
14 FATHER'S NAME FIRST MIDDLE LAST John Scott				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Velaria Lawson					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No				16b SOCIAL SECURITY NO. unknown		17 INFORMANT ADDRESS 2006 Fairview Dr Florence Montague Frederickburg, Va.			
18 CAUSE OF DEATH (Enter only one cause per line for part 1, 2, and 3) PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiogenic Shock</u> DUE TO: OR AS A CONSEQUENCE OF: (b) <u>Ventricular Ectopy</u> DUE TO: OR AS A CONSEQUENCE OF: (c) <u>Coronary Artery Disease</u> Conditions, if any, which gave rise to immediate cause (d), stating the underlying cause last								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (1) (this hospital) attended the deceased from 6/4 19 87 to 6/4 19 87, that (1) (we) last saw the deceased alive on 6/4 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (I) do not know the exact date of death.									
22b SIGNATURE Stanley				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c DATE SIGNED 6/5/87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) STANLEY JOSEF.				22e ADDRESS 4467 OLD BARBARIT HVE TEMPLE HILL MD 20748					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 8 June 1987		23c NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d LOCATION CITY OR TOWN COUNTY STATE Suitland PG Md			
24 FUNERAL DIRECTOR NAME Robert E Wilhelm Funeral Home				ADDRESS Suitland, MD.		25a DATE REC'D BY REGISTRAR JUN 9 1987		25b REGISTRAR'S SIGNATURE Julia Davidson-Randall	

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March 21/92

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 18068

1. FOR STATE REGISTRAR		2a. DECEASED NAME (TYPE OR PRINT) <i>Covalec (nmn) Kleinschmidt</i>		2b. DATE KNOWN OF DEATH ESTI. MATED <i>June 9 1987</i>	
3. SEX <i>F</i>	4. RACE <i>W</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>Oct. 28 1900</i>	6. AGE (LAST BIRTHDAY) <i>86 YRS.</i>	7c. DATE PRONOUNCED DEAD <i>June 9 1987</i>	7d. TIME OF DEATH <i>6:21 PM</i>
7a. BIRTHPLACE (STATE OR) <i>Thayer, Mo.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		7. BALTIMORE CITY OR COUNTY OF DEATH <i>Prince Georges</i>	
10. CITY OR TOWN OF DEATH <i>Laurel</i>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>12202 Brittany Pl</i>		12a. USUAL RESIDENCE (FOR MOST OF WORKING LIFE) <i>Ret. Medical</i>	
13a. STATE <i>Md.</i>		13b. COUNTY <i>Prince Georges</i>		13c. CITY OR TOWN <i>Laurel</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Charles P. Sargent</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Mary E. Kenner</i>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>no</i>	
16a. SOCIAL SECURITY NO. <i>064-36-3604</i>		17. INFORMANT <i>Esther Meyers same as 13c</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I DEATH WAS CAUSED BY:		
888 IMMEDIATE CAUSE (a) <i>Sagoris</i>		
DUE TO, OR AS A CONSEQUENCE OF		
(b) <i>Fracture L. hip</i>		
DUE TO, OR AS A CONSEQUENCE OF		
(c)		

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>None</i>			
19a. DATE OF OPERATION <i>4-22-82</i>	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <i>Fracture L. hip</i>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>	21b. TIME OF INJURY HOUR MIN MONTH DAY YEAR <i>1:30 P.M. 4 25 87</i>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <i>Fall</i>	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21e. PLACE OF INJURY (AT HOME STREET, FACTORY, FARM, ETC.) <i>Home</i>	21f. LOCATION (CITY OR TOWN COUNTY STATE) <i>Brittany Pl, Laurel Prince Georges Md</i>	

22a. I certify that I took charge of the remains described above, held on death resulted from:		Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion	
Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		TITLE (SPECIFY) <i>Dep</i> MEDICAL EXAMINER	
ACTUAL SIGNATURE <i>[Signature]</i>		DATE SIGNED <i>June 9 1987</i>	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Cremation</i>	23b. DATE <i>6/11/87</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Balto. Wash. Crematory</i>	23d. LOCATION (CITY OR TOWN COUNTY STATE) <i>Laurel P.G. Maryland</i>
24. FUNERAL DIRECTOR NAME ADDRESS <i>7601 Sandy Spring Rd. Fleck Funeral Home, Inc. Laurel, Md. 20707</i>		25a. DATE REC'D. BY REGISTRAR <i>JUN 12 1987</i>	25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING," IN PENCIL IN ITEM 18. GIVE PAGE NO. AND DATE TO FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORMS 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100. PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE MD. 21201



CHRYSLER

BOX COTTON FIBER

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and correctly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG NO. 8718069			
1. DECEASED NAME (TYPE OR PRINT) FIRST: <u>JOAN</u> MIDDLE: <u>(NMN)</u> LAST: <u>KNEISLEY</u>				2a. DATE OF DEATH MONTH <u>6</u> DAY <u>18</u> YEAR <u>87</u> 2b. HOUR <u>4:50</u> AM <input checked="" type="checkbox"/> PM <input type="checkbox"/>			
3. SEX <u>Female</u>		4. RACE <u>Caucasian</u>		5. DATE OF BIRTH MONTH <u>July</u> DAY <u>23</u> YEAR <u>1918</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>68</u> YRS. IF UNDER 1 YEAR MONTHS <u></u> DAYS <u></u> IF UNDER 24 HRS. HOURS <u></u> MIN. <u></u>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Georgia</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U S A</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Prince George's County</u> MD	
10. CITY OR TOWN OF DEATH <u>Hyattsville</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>7305 Upshur Street</u>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Retired</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>DC Government</u>	
13a. STATE <u>Maryland</u>		13b. COUNTY <u>Pr. George's</u>		13c. CITY OR TOWN <u>Hyattsville</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST <u>Eugene</u> MIDDLE <u></u> LAST <u>George</u>		15. MOTHER'S MAIDEN NAME FIRST <u>Nona</u> MIDDLE <u></u> LAST <u>Helmly</u>		13e. STREET ADDRESS / ZIP CODE <u>7305 Upshur Street 20784</u>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>NO</u>		16b. SOCIAL SECURITY NO. <u>579-24-9513</u>		17. INFORMANT ADDRESS <u>2201 Patuxent River Road Gambrills, MD 21054</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (b), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Metastatic, Recurrent Ovarian</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6 weeks</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Chronic Obstructive Pulmonary Disease</u>							
19a. DATE OF OPERATION <u>5/3/87</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Recurrent Ovarian Carcinoma</u>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR <u></u> A.M. <u></u> MONTH <u></u> DAY <u>19</u> P.M. <u></u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET <u></u> CITY OR TOWN <u></u> COUNTY <u></u> STATE <u></u>			
22a. I certify that (I) (this hospital) attended the deceased from <u>6/11</u> 19 <u>87</u> , to <u>6/11</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>6/11</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.							
22b. SIGNATURE <u>[Signature]</u> DEGREE <u>M.D.</u>				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>6/18/87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>SP Sandra</u>				22e. ADDRESS <u>7500 Hanover Pkwy Greenbelt MD 20870</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>JUNE 20, 1987</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		23d. LOCATION CITY OR TOWN <u>Suitland, Pr. George's</u> COUNTY <u>MD</u> STATE <u></u>	
24. FUNERAL DIRECTOR NAME <u>Beall Funeral Home</u>		16000 Annapolis Road <u>Bowie, MD 20715-3043</u>		25a. DATE REC'D. BY REGISTRAR <u>JUN 22 1987</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

218-50-0073

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified on page 4.

BP _____

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 18070
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ANNA KYLER			2a. DATE OF DEATH MONTH DAY YEAR 6 25 87		2b. HOUR 12³⁰ AM	
3. SEX F		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR 9 9 10		
7a. BIRTHPLACE COUNTRY GEORGIA		7b. CITIZEN OF WHAT COUNTRY? USA		8. AGE (IN YEARS LAST BIRTHDAY) YRS MONTH DAYS 76		
10. CITY OR TOWN OF DEATH LANHAM		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MAGNOLIA GARDENS NSG HOME		9. BALTIMORE CITY OR COUNTY OF DEATH P.G. County MD.		
12a. USUAL RESIDENCE IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION STATE CITY OR TOWN Maryland PG Lanham		13a. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13b. STREET ADDRESS / ZIP CODE 8118 Good Luck Road 20706		
14. FATHER'S NAME MIDDLE LAST Unknown		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO N/A		
16b. SOCIAL SECURITY NO. 577-38-7839		17. INFORMANT ADDRESS Serina Wiley/5012 Rhode Island Ave Hyattsville, Md 20781		18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) NATURAL CAUSES DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: (b) ORGANIC BRAM SYNDROME DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 0		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (1) (the hospital) attended the deceased from 6/2 to 6/25 87 that (1) (we) lost 6/2 above (to be signed only on _____ and that in my (our) opinion death occurred on the date and hour and from the causes stated						
22b. SIGNATURE [Signature]		DEGREE		22c. DATE SIGNED 6/2/87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) PSCHLOSSER MD		22e. ADDRESS 1500 GREENWAY CRT DR GREENBELT MD				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE June 27, 1987		23c. NAME OF CEMETERY OR CREMATORY Harmony Memorial park		
23d. LOCATION CITY OR TOWN COUNTY STATE Landover PG Maryland		23e. DATE RECEIVED BY REGISTRAR JUL 02 1987				
24. FUNERAL DIRECTOR NAME ADDRESS J.B. Jenkins FH/7474 Landover Rd/Landover, Md		25. REGISTRAR'S SIGNATURE [Signature]				

TO THE DIRECTOR
BUREAU OF PLANT INDUSTRY
WASHINGTON, D. C.

FROM THE
DIRECTOR
BUREAU OF PLANT INDUSTRY
WASHINGTON, D. C.

RECEIVED
JAN 10 1914
BUREAU OF PLANT INDUSTRY
WASHINGTON, D. C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8718071
REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1 DECEASED NAME (TYPE OR PRINT)		3 SEX		4 RACE	
FIRST MIDDLE LAST Mabel A. Lawson		Female		Caucasian	
5. DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	
MONTH DAY YEAR Dec 10 1909		77 YRS		West Virginia	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH		10. CITY OR TOWN OF DEATH	
		Prince George's MD.		Clinton	
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Southern Maryland Hospital		Homemaker		Home	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN	
Virginia		Pulaski		Dublin	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	
FIRST MIDDLE LAST Mitchell Herold		FIRST MIDDLE LAST Minnie Rupe		N/A	
16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
		Family Records			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I DEATH WAS CAUSED BY					
IMMEDIATE CAUSE (a) <u>Respiratory Failure</u>					
DUE TO, OR AS A CONSEQUENCE OF (b) <u>COPD</u>					
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Lung Moss.</u>					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u></u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
		HOUR A.M. MONTH DAY YEAR P.M. 19			
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION (CITY OR TOWN, COUNTY, STATE)	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		Feb 87		March 10 87	
22a. I certify that (I) (this hospital) attended the deceased from <u>March 10 1987</u> to <u>March 10 1987</u> , that (I) (we) last saw the deceased alive on <u>March 10 1987</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
<u>Dr. Stanley Josef</u>				4/17/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
		4467 Old Branch Ave. Temple Hills, MD 20748			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		3-16-87		Highland Memory Gardens-Dublin, Virginia	
24. FUNERAL DIRECTOR		25a. DATE REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
NAME Lee Funeral Home, Inc. Old Alexander Ferry Rd., Clinton, MD 20735		JUN 24 1987		Julia Benson-Randall	

[Handwritten signature]

11/14/84

11/14/84

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056623 JUN 15

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PA-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 18072

1. DECEASED NAME (TYPE OR PRINT) IRENE F. LEAK										2a. DATE KNOWN OF DEATH 6-8-87		2b. HOUR 19			
3. SEX Female		4. RACE White		5. DATE OF BIRTH 2 11 1914		6. AGE (IN YEARS) 73		7. IF UNDER 1 YR. NO		7. IF UNDER 24 HRS. NO		2c. DATE PRONOUNCED DEAD 6-8-87		2d. HOUR 19	
8a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Alabama				8b. CITIZEN OF WHAT COUNTRY? USA				8c. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges			
9. CITY OR TOWN OF DEATH Lanham				10. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION Doctors Hospital				11. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife				12. KIND OF BUSINESS OR INDUSTRY own home			
13a. STATE Maryland				13b. CITY OR TOWN Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES		13e. STREET ADDRESS 14005 Wildwood Drive				20904	
14. FATHER'S NAME (unknown)						15. MOTHER'S MAIDEN NAME (unknown)									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? N/A				16b. SOCIAL SECURITY NO. 108-07-6292				17. INFORMANT Thomas Leak-step-son				ADDRESS 17517 Skyline Dr. Ashton, Md. 20861			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Empty same DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION (CITY OR TOWN, COUNTY, STATE)							
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion															
ACTUAL SIGNATURE Augusto P. Rodriguez				TITLE (SPECIFY) Physician				MEDICAL EXAMINER				DATE SIGNED 6-8-87			
EXAMINER'S NAME (TYPE OR PRINT) Augusto P. Rodriguez				ADDRESS 5009 Rayburn Ct., Ck Sp. Md 20746											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 6-11-1987		23c. NAME OF CEMETERY OR CREMATORY Leak Chapel				23d. LOCATION (CITY OR TOWN, COUNTY, STATE) Stanley Virginia					
24. FUNERAL DIRECTOR Hines/Rinaldi Funeral Home				11800 N.H. Ave., Sil. Spr. Md.				25a. DATE REC'D BY REGISTRAR JUN 15 1987				25b. REGISTRAR'S SIGNATURE Julia Anderson-Randall			



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100% COTTON FIBER
MADE IN
INDONESIA

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8718073

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Linwood Lee			2a. DATE OF DEATH June 14, 1987			2b. HOUR M			
3. SEX Male		4. RACE Negro		5. DATE OF BIRTH 9 14 1910		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.		7. UNDER 1 YEAR IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD.			
10. CITY OR TOWN OF DEATH Bowie		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 12409 Duckett Town Rd.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Truck Driver		12b. KIND OF BUSINESS OR INDUSTRY Retired	
13a. STATE Md.		13b. COUNTY P.G.		13c. CITY OR TOWN Bowie		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 12409 Duckett Town Rd. 20715	
14. FATHER'S NAME FIRST MIDDLE LAST Robert Lee			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes WWII			
16b. SOCIAL SECURITY NO. 579-07-2191			17. INFORMANT Althea Adams			ADDRESS 2323 Wyngate Rd. Suitland, Md.			
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cirrhosis aet.</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Comp. aet. Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Comp. Atherosclerosis</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u> <u>5 yr.</u> <u>10 yr.</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>0</u>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NO: WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I the hospital) attended the deceased from <u>6/1</u> 19 <u>86</u> to <u>Jun 3</u> 19 <u>87</u> that (I was lost saw the deceased alive on <u>Jun 3</u> 19 <u>87</u> , and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I we did not view the body after death.									
22b. SIGNATURE <u>Jack C. Meschel</u>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>6/16/87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jack C. Meschel, M.D.			22e. ADDRESS 5806 Baltimore Ave Hyattsville, Md 20781						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE June 16, 1987		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland P.G. Md.		
24. FUNERAL DIRECTOR NAME Comer-Hodges F.H.			ADDRESS 4901 Marlboro Rd. Coral Hills, Md.		25. DATE REC'D. BY REGISTRAR JUN 22 1987				
25. REGISTRAR'S SIGNATURE <u>John H. Anderson</u>									



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 18074

1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) JOHN T. LEISHER			2a. DATE OF DEATH MONTH DAY YEAR Jun 4, 1987		2b. HOUR MIN. 730P
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Oct 22, 1889		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN. 97y	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD.	
10. CITY OR TOWN OF DEATH Laurel	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Greater Laurel Beltsville Hosp		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer	12b. KIND OF BUSINESS OR INDUSTRY Self-employed	
13a. STATE Maryland	13b. COUNTY Howard	13c. CITY OR TOWN Scaggsville	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 8262 Leishear Rd. 20707	
14. FATHER'S NAME FIRST MIDDLE LAST John T. Leishear		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Kizeahe Chalk			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no		16b. SOCIAL SECURITY NO. 216-44-5138		17. INFORMANT ADDRESS Doris Styers same as above	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SUDDEN CARDIAC DEATH DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) PROBABLE MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a) PERIPHERAL VASCULAR DISEASE					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 6/4 19 87 , to 6/4 19 87 , that (I) (we) last saw the deceased alive on 6/4 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.					
22b. SIGNATURE Gregory A. Compton		DEGREE MD		22c. DATE SIGNED 6-4-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GREGORY A COMPTON		22e. ADDRESS 8317 Cherry Lane Laurel MD 20707			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE June 6, 1987		23c. NAME OF CEMETERY OR CREMATORY Emmanuel Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Scaggsville Md		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE JUNO 9 1987 Julia Davidson-Rublee			
24. FUNERAL DIRECTOR NAME ADDRESS Donaldson Funeral Home P.A. Laurel, Maryland					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 8718075

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
NORMAN EDWARD LE ROUX		JUNE 21 1987		7:38P M	
3 SEX	4 RACE	5. DATE OF BIRTH	6 AGE (IN YEARS LAST BIRTHDAY)	8 IF UNDER 1 YEAR	
Male	White	Jan. 11, 1923	64 YRS	IF UNDER 24 HRS.	
7a BIRTHPLACE (COUNTRY)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH		
Washington, D.C.	U.S.A.	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Prince George's MD		
10 CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY
Lanham	Doctors' Hospital of Pr. Geo. Co.		Senior Auditor		Sovran Bank
13a STATE		13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS?	13e STREET ADDRESS / ZIP CODE
Maryland		Pr. Geo.	Lanham	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	7020 Kepner Court/20706
14 FATHER'S NAME		15 MOTHER'S MAIDEN NAME		16a ADDRESS	
Edward J. LeRoux		Corrine E. Brothers		7020 Kepner Court	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO.		17 INFORMANT	
No		219-12-2563		Alice R. LeRoux/Lanham, Maryland 20706	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).					
PART I. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) <i>Cardiac Arrest</i>					
DUE TO, OR AS A CONSEQUENCE OF					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost					
(b) <i>Diffuse Ischemic Cardio myopathy</i>					
DUE TO, OR AS A CONSEQUENCE OF					
(c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
		HOUR A.M. MONTH DAY YEAR			
		P.M. 19			
21d INJURY OCCURRED		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)		21f LOCATION	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from <i>6/1</i> , 19 <i>87</i> , to <i>6/26</i> , 19 <i>87</i> , that (I) (we) last saw the deceased alive on <i>one week ago 1987</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.					
22b SIGNATURE		DEGREE		22c DATE SIGNED	
<i>M Hernandez</i>		MD		6/22/87	
22d PHYSICIAN'S NAME (TYPE OR PRINT)		22e ADDRESS			
T. J. Hernandez		14300 Gallant Fox Lane, Suite 126 Bowie, Maryland 20715			
23a BURIAL, CREMATION, REMOVAL (SPECIFY)	23b DATE	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION		
Burial	6-24-87	Gate of Heaven Cem.	CITY OR TOWN COUNTY STATE		
		Silver Spring, Montgomery, MD			
24 FUNERAL DIRECTOR'S NAME		25a DATE REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE	
Rendon-Hale Lanham Funeral Home		JUN 25 1987		<i>Julia Rendon-Hale</i>	
9013 Annapolis Road., Lanham, Maryland 20706					

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Small machine

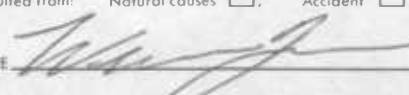

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101A 32 081

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER. ALONG WITH FORM PM-3, RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 8076	
1- STATE REGISTRAR Unkn.87-63											
1 DECEASED NAME (TYPE OR PRINT) Bonnie Gaye L oyd							2a DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH 6 DAY 28 YEAR 1987		2b HOUR 9:10 P M		
3 SEX F	4 RACE white	5 DATE OF BIRTH MONTH 01 DAY 16 YEAR 62	6 AGE (IN YEARS) LAST BIRTHDAY MONTH 25 YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7c DATE PRONOUNCED DEAD MONTH 6 DAY 28 YEAR 1987		2d HOUR 9:10 P M			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington DC		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Prince George's County, MD					
10 CITY OR TOWN OF DEATH Langley Park		11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1410 Kanawha St. 20783				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) unemployed		12b KIND OF BUSINESS OR INDUSTRY N/A			
13a STATE Md. 13b COUNTY Prince George 13c CITY OR TOWN Langley Park										13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e STREET ADDRESS 1410 Kanawha St. 20783	
14 FATHER'S NAME Rollin J. Dowell				15 MOTHER'S MAIDEN NAME Linda Shifflett							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b SOCIAL SECURITY NO. 218-84-0958		17 INFORMANT ADDRESS Rollin Dowell 9114 Margo Lane Lanham 20706							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Gunshot Wound of Chest (unspecified weapon) DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1											
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? P.M. 6/ 28/1987		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) subject shot							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) house		21f. LOCATION STREET 1410 Kanawha St., CITY OR TOWN Langley Pk., COUNTY Pr.Geo., STATE Md.							
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE 		TITLE (SPECIFY) M.D. Assistant				DATE SIGNED 6/29/87					
EXAMINER'S NAME (TYPE OR PRINT) William M. Zane, M.D.		ADDRESS 111 Penn St.									
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b DATE 6/30/87		23c NAME OF CEMETERY OR CREMATORY Metropolitan Crematory Alexandria Fairfax Virginia		23d LOCATION CITY OR TOWN Beltsville Md COUNTY 20705 STATE Virginia					
24 FUNERAL DIRECTOR Donald V. Borgwardt		25a DATE REC'D BY REGISTRAR JUL 06 1987		25b REGISTRAR'S SIGNATURE 							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 12 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or reinterment.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 7 1 8 0 7 7 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Lois L. Lubner				2a. DATE OF DEATH MONTH DAY YEAR May 30, 1987		2b. HOUR 5:20P M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 20, 1928		6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS 58	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges County MD.	
10. CITY OR TOWN OF DEATH Laurel		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Greater Laurel Beltsville Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mill Worker		12b. KIND OF BUSINESS OR INDUSTRY Cotton Mill	
13a. STATE Maryland				13b. COUNTY Howard		13c. CITY OR TOWN Savage	
14. FATHER'S NAME FIRST MIDDLE LAST Vivian Paul Lubner				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rita Waters			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 212-26-5540		17. INFORMANT ADDRESS Elmer Lubner 8925 Washington St Savage, Md 20763			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure. DUE TO, OR AS A CONSEQUENCE OF (b) Severe Cardiomyopathy. DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 5-11-1987 to 5-30-1987 that (I) (we) last saw the deceased alive on 5-30-1987 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE M. YUSUF				DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) M. YUSUF				22e. ADDRESS 3450 Fort Meade Road Laurel MD 20707			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE June 2, 1987		23c. NAME OF CEMETERY OR CREMATORY Savage Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Savage Howard Maryland	
24. FUNERAL DIRECTOR NAME ADDRESS Donaldson Funeral Home P.A. Laurel, Maryland				25a. DATE REC'D. BY REGISTRAR JUN 11 1987			
				25b. REGISTRAR'S SIGNATURE Julia Dindon-Randall			

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 18078

FOR
1- STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		2a. DATE KNOWN OF DEATH		2b. DATE OF ESTI- MATED		2c. DATE PRONOUNCED DEAD		2d. HOUR	
Alice Marie Lucy		6-4-1987		6-4-1987		5:15P			
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	7. IF UNDER 1 YR	7. IF UNDER 24 HRS	8. MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH	
Female	Black	Nov. 4, 1974	12 YRS.			NEVER MARRIED <input checked="" type="checkbox"/>		Prince George's County MD	
10. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	11. CITIZEN OF WHAT COUNTRY?		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY				
Washington, D.C.	United States		Student		Education				
13. CITY OR TOWN OF DEATH	14. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		15. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		16. STATE		17. COUNTY		
Cheverly	Prince George's General Hospital		D.C.		Washington				
18. FATHER'S NAME	19. MOTHER'S MAIDEN NAME		20. INSIDE CITY LIMITS?		21. STREET ADDRESS		22. CITY OR TOWN		
Herbert W. Lucy	Sandra Richards		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1306 Franklin Street N.E.		ton, D.C.		
23. WAS DECEASED EVER IN U.S. ARMED FORCES?		24. SOCIAL SECURITY NO.		25. INFORMANT		26. ADDRESS			
No		577-96-8957		Sandra Lucy		1306 Franklin St. N.E. Washing-			
27. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART I DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>Electrocution complicated by drowning</u>									
DUE TO, OR AS A CONSEQUENCE OF									
(b) _____									
DUE TO, OR AS A CONSEQUENCE OF									
(c) _____									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1									
28. DATE OF OPERATION		29. CONDITION FOR WHICH OPERATION WAS PERFORMED?				30. AUTOPSY?			
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
31. EXTERNAL CAUSE WAS		32. TIME OF INJURY		33. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		4:00PM 6-4-1987		Subject came in contact with live wire					
34. INJURY OCCURRED		35. PLACE OF INJURY (AT HOME STREET, FACTORY FARM, ETC.)		36. LOCATION					
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		street		Central Ave. & Addison Road, Prince George's County, MD					
37. I certify that I took possession of the remains described above, held on									
death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
38. ACTUAL SIGNATURE		39. TITLE (SPECIFY)		40. DATE SIGNED		41. DATE			
Charles P. Kokes, M.D.		M.D. Assistant		6-5-87		6-5-87			
42. EXAMINER'S NAME		43. ADDRESS		44. DATE					
(TYPE OR PRINT)		111 Penn St., Balto., MD 21201							
45. BURIAL, CREMATION, REMOVAL		46. DATE		47. NAME OF CEMETERY OR CREMATORY		48. LOCATION			
Burial		6/11/87		Maryland Natl. Mem. Pk.		Laurel, Prince Georges, Maryland			
49. FUNERAL DIRECTOR		50. ADDRESS		51. DATE REC'D. BY REGISTRAR		52. REGISTRAR'S SIGNATURE			
McGuire Funeral Service, 7400 Georgia Ave. N.W.		Washington, D.C.		6/10/87					

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAYS ARE NECESSARY, RETURN THE CERTIFICATE TO THE REGISTRAR. IN PENCIL IN ITEM 18, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 19, GIVE PAGES 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 4 AND 5 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8718079

FOR STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST FRED Frank LYNCH Sr.		2a. DATE OF DEATH MONTH DAY YEAR JUNE 19 1987 2b. HOUR 12:27A _M	
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR Sept. 5, 1920	6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PA.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD.
10. CITY OR TOWN OF DEATH Camp Springs	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Malcolm Grow Hospital AAFB	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR Self-Employed
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			
13a. STATE Maryland	13b. COUNTY P. G.	13c. CITY OR TOWN Clinton	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST George Lynch		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sadie Fligger	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes WWII	16b. SOCIAL SECURITY NO. 172-16-5757	17. INFORMANT ADDRESS Doris Lynch Same as 13 A-E	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF (c)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 19____, to 19____, that (I) (we) lost saw the deceased alive on 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
23a. SIGNATURE BRAND J. JOHNSON, Capt. USAF, MC 291-66-3647 AFSC 9341 Malcolm Grow USAF Medical Center			23b. DATE SIGNED JUNE 87
23c. PHYSICIAN'S NAME BRAND J. JOHNSON, Capt. USAF, MC 291-66-3647 AFSC 9341 Malcolm Grow USAF Medical Center			23d. ADDRESS MALCOLM GROW USAF MED CTR (MAC)/SGRA NEWS AFB, WASHINGTON, D.C. 20331-5300
23a. BURIAL, CREMATION, REMOVAL SPEC Burial	23b. DATE 06/23/87	23c. NAME OF CEMETERY OR CREMATORY Maryland Veterans Cem.	23d. LOCATION CITY OR TOWN COUNTY STATE Cheltenham Prince Georges Md
24. FUNERAL DIRECTOR Lee Funeral Home, Inc., 6633 Old Alexander Ferry Rd Clinton, Md 20735		25a. DATE REC'D. BY REGISTRAR JUN 24 1987	25b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit. Then please remove container tags. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene for national, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 above, injury, or other traumatic event, the medical examiner must be notified.

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1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 7

REG. NO.

1 8 0 8 0

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Anthony M. MADDEN			2a. DATE OF DEATH MONTH DAY YEAR June 7, 1987		2b. HOUR 2:50 PM
3. SEX Male	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR 9 21 05		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ohio	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges' MD.		
10. CITY OR TOWN OF DEATH Lanham	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) AMI Doctors Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) insurance sales	12b. KIND OF BUSINESS OR INDUSTRY private	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE COUNTY Md Prince George Greenbelt		13b. CITY OR TOWN Greenbelt	13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13d. STREET ADDRESS / ZIP CODE 149 Westway Rd 20770	
14. FATHER'S NAME FIRST MIDDLE LAST Martin J. Madden		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary J. Wilhere			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO 281-22-6762		17. INFORMANT ADDRESS Michael G. Madden PO Box 8 Greenbelt 20770	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Bilateral pneumonia</i> DUE TO, OR AS A CONSEQUENCE OF b) _____ DUE TO, OR AS A CONSEQUENCE OF c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. <i>Diabetes Mellitus, Emphysema, Coccydynia</i>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSE OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN PART 2, OR ABOVE)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY STATE 516 ST 4/7 MD	
22a. I certify that (I) (this hospital) attended the deceased from <i>6/7</i> 19 <i>87</i> , to <i>6/7</i> 19 <i>87</i> , that (I) (we) last saw the deceased alive on <i>6/7</i> 19 <i>87</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>[Signature]</i> DEGREE				22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>TAMIE CHARLTON</i>				22e. ADDRESS <i>8824 Cunningham Drive, D.H. Md 20760</i>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6/10/87		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven	
23d. LOCATION PORTO Silver Spring Montgomery Md		23e. DATE REC'D. BY REGISTRAR JUN 12 1987			
24. FUNERAL DIRECTOR NAME Donald V. Borgwardt		ADDRESS 4400 Powder Mill Rd. Beltville Md. 20705		25. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

MEDICAL CERTIFICATION

9 9

Handwritten notes on lined paper, including a large '1' and various illegible scribbles.

020422

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM 10, TO RETAIN PAGES 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

18081

1. FOR STATE REGISTRAR		2a. DATE KNOWN OF DEATH		3. DATE OF BIRTH		4. AGE (IN YEARS)		5. IF UNDER 1 YR.		6. IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		7d. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2b. DATE KNOWN OF DEATH		3. DATE OF BIRTH		4. AGE (IN YEARS)		5. IF UNDER 1 YR.		6. IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		7d. HOUR	
Mary J. Maghan		June 9, 1987		May 26, 1900		87						June 9, 1987		P	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITY, OF WHAT COUNTRY		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH									
Virginia		U.S.A.				Prince Georges									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY									
Hyattsville		7401 New Hampshire Ave. # 416		Clerical		Navy Dept.									
13a. STATE		13b. CITY		13c. STREET		13d. INSIDE CITY LIMITS?		13e. YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13f. STREET		13g. CITY		13h. STATE	
Maryland		Prince Georges		Hyattsville						7401 New Hampshire Ave. #416				20783	
14. DECEASED'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
John Henry Jackson		Emma Jane Morgan		no		579-50-0697		grandson		9 Lee Avenue					
								Brian Mahan		Takoma Park, Md. 20912					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH													
		Acute Myocardial Dis													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?											
None		None		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion													
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED											
John S. Rogers, M.D.		M.D. Dep.		June 9, 1987											
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS													
John S. Rogers, M.D.		1919 Seminary Rd., Silver Spring, Md.													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE									
Burial		June 12, 1987		Gate of Heaven Cemetery		Silver Spring Montgomery Md.									
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE											
Francis J. Collins, Jr.		June 15, 1987		John S. Rogers											
500 University Blvd. West, Silver Spring, Md. 20901															

CHIEF IN CHARGE

30% COLLECT



WOMAN

2000

6/10/00

10091

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 18082	
1- STATE REGISTRAR											
1 DECEASED NAME (TYPE OR PRINT) LALAH Lucille Malone MALONE										2a DATE KNOWN OF DEATH MONTH DAY YEAR 6-14 1987	
3 SEX Female 4 RACE White 5 DATE OF BIRTH MONTH DAY YEAR APRIL 9, 1901 6 AGE (IN YEARS LAST BIRTHDAY) 86 YRS.										2b HOUR 944	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina 7b CITIZEN OF WHAT COUNTRY? USA 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>										2c DATE PRONOUNCED DEAD 6-14 1987	
9 BALTIMORE CITY OR COUNTY OF DEATH Prince George's County											
10 CITY OR TOWN OF DEATH Bowie 11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bowie Health Center										12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Home Maker	
12b KIND OF BUSINESS OR INDUSTRY own home											
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a STATE Maryland 13b COUNTY Pr. George's 13c CITY OR TOWN Bowie										13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e STREET ADDRESS 11912 Galaxy Lane										20715	
14 FATHER'S NAME FIRST MIDDLE LAST Thomas Newlin										15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Eva Williams	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO (IF YES, GIVE WAR OR DATES) - - -										16b SOCIAL SECURITY NO. 577-52-2164	
17 INFORMANT Betty J. Malone										ADDRESS 11912 Galaxy Lane Bowie, Maryland 20715	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ischemic cardiac disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) - - - DUE TO, OR AS A CONSEQUENCE OF (c) - - -										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 Status post 2-year old right hip fracture operation, infected left hip fracture.											
19a DATE OF OPERATION										19b CONDITION FOR WHICH OPERATION WAS PERFORMED?	
20a EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH										20b TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19	
20c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21a INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK										21b PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	
21c LOCATION STREET CITY OR TOWN COUNTY STATE											
22a I certify that I took charge of the remains described above, held on death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE Augusto P. Rodriguez M.D. TITLE (SPECIFY) Deputy MEDICAL EXAMINER										DATE SIGNED 6-14-87	
EXAMINER'S NAME (TYPE OR PRINT) Augusto P. Rodriguez, M.D. ADDRESS 5009 Rayburn Ct., Temple Hills, MD											
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial										23b DATE JUNE 16, 1987	
23c NAME OF CEMETERY OR CREMATORY Arlington National Cem.										23d LOCATION CITY OR TOWN COUNTY STATE Arlington, Arlington, Virginia	
24 FUNERAL DIRECTOR NAME Beall Funeral Home										25a DATE REC'D. BY REGISTRAR JUN 22 1987	
25b REGISTRAR'S SIGNATURE Beall Funeral Home											

STANDARD INTERNATIONAL BANKING CORPORATION

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8718083

FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) NATHAN MANIGAULT			2a. DATE OF DEATH MONTH DAY YEAR 06 25 87			2b. HOUR MIN. 2:10 A	
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR July 1, 1947		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 39	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) South Carolina		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD	
10. CITY OR TOWN OF DEATH CLINTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Maryland Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Foreman	
12b. KIND OF BUSINESS OR INDUSTRY Wash Gas Lt Co							
13a. STATE Md		13b. COUNTY PG		13c. CITY OR TOWN Clinton		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE 8604 Pretoria Court (20735)							
14. FATHER'S NAME FIRST MIDDLE LAST Nathan Manigault				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bernice Green			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 577-64-7262		17. INFORMANT ADDRESS Mrs Rita Manigault/8604 Pretoria Court			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial infarction DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Coronary Artery Disease DUE TO, OR AS A CONSEQUENCE OF (c) Hypertension APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hrs. 10 plus yrs.							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a Marked exogenous obesity							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 5/20/87 to 6/24/87 , that (I) (we) last saw the deceased alive on 6/1/87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Wendy H. Preece MD				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 26 June 1987	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. M. PILLOR				22e. ADDRESS 6188 OXON HILL RD, OXON HILL MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE June 30, 1987		23c. NAME OF CEMETERY OR CREMATORY Harmony Memorial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Landover Md.	
24. FUNERAL DIRECTOR NAME Marshall's Funeral Home				25a. DATE REC'D. BY REGISTRAR JUN 30 1987			
4217 9th St NW: Washington, D.C. 20011				25b. REGISTRAR'S SIGNATURE Julia Barber-Rodriguez			

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8718084

REG NO

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Bernice Elizabeth Mathis			2a. DATE OF DEATH MONTH DAY YEAR June 8, 1987		2b. HOUR M.
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR March 28, 1937		6. AGE (IN YEARS LAST BIRTHDAY) 50 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, DC	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD.	
10. CITY OR TOWN OF DEATH Camp Springs	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 5210 Carswell Ave. #103		12a. USUAL OCCUPATION (TYPE OF WORK, LIST MOST OF WORKING LIFE) Homemaker	12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. STATE Maryland	13b. COUNTY P.G.	13c. CITY OR TOWN Camp Springs	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 5210 Carswell Ave. #103 20748	
14. FATHER'S NAME FIRST MIDDLE LAST John Robertson		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bertha Steel			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No N/A		16b. SOCIAL SECURITY NO. 577-50-0487		17. INFORMANT ADDRESS Leroy Mathis Same as 13 A-E	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE CARDIOPULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) ATHEROSCLEROTIC CARDIOVASCULAR DISEASE. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) DIABETES MELLITUS, APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH MINUTES. YEARS. YEARS.					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: RENAL FAILURE, PERIPHERAL ARTERIAL DISEASE. Hypertension					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from May 19 1987, 19_____, to June 8, 1987, that (I) (we) lost saw the deceased alive on June 8, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE 		DEGREE M.D.		22c. DATE SIGNED JUNE 8 1987	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) PETER W. YIM M.D.		22e. ADDRESS 7900 Old Branch Ave. #101 Clinton Md. 20735			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 06/11/87	23c. NAME OF CEMETERY OR CREMATORY Southern Memorial Gard.		23d. LOCATION CITY OR TOWN COUNTY STATE Dunkirk Calvert Maryland
24. FUNERAL DIRECTOR Lee Funeral Home, Inc.		25a. DATE REC'D BY REGISTRAR JUN 16 1987		25b. REGISTRAR'S SIGNATURE 	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

6633 Old Alexander Ferry Rd Clinton, Md 20735

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 18085

1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Robert F. McClelland			2a. DATE OF DEATH MONTH DAY YEAR June 15, 1987		2b. HOUR 11:39A.M.
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR May 1, 1932		6. AGE (IN YEARS LAST BIRTHDAY) 55 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD.
10. CITY OR TOWN OF DEATH Cheverly	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Prince George's Hospital Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Cable splicer (RET)		12b. KIND OF BUSINESS OR INDUSTRY D.C. Government
13a. STATE Maryland			13b. COUNTY Pr Geo	13c. CITY OR TOWN Lothian	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST James F. McClelland			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Rathman		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. Korean War 677-44-0655		17. INFORMANT ADDRESS 7424 Garrison Road David P. McClelland/Hyattsville, MD 20784	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Compensatory Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cardiomyopathy</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>6/14</u> 19 <u>87</u> to <u>6/15</u> 19 <u>87</u> that (I) (we) last saw the deceased alive on <u>6/14</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.					
22b. SIGNATURE <u>Barry Rosenberg</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 6/15/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Barry Rosenberg, M.D.		22e. ADDRESS 6501 Landover Rd., Cheverly, Maryland			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 6-18-87	23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood, Pr. Geo., Maryland	
24. FUNERAL DIRECTOR NAME Rendon-Hale Lanham Funeral Home		ADDRESS 9013 Annapolis Road, Lanham, Maryland 20706		25a. DATE RECEIVED BY REGISTRAR JUN 18 1987	
		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it is the funeral director's page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 through 4 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be mailed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified so that an autopsy can be performed.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 18086

REG. NO.

1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR P M			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Mary Jane McCormick				June 14, 1987				6:16 P M			
3. SEX female		4. RACE caucasian		5. DATE OF BIRTH MONTH DAY YEAR August 2, 1928		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 58		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, DC		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD.					
10. CITY OR TOWN OF DEATH Lanham		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 6704 Terra Alta Drive				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) clerk		12b. KIND OF BUSINESS OR INDUSTRY government			
13a. STATE Maryland				13b. COUNTY Pr George's		13c. CITY OR TOWN Lanham		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			
13e. STREET ADDRESS / ZIP CODE 6704 Terra Alta Drive 20706				14. FATHER'S NAME FIRST MIDDLE LAST Albert Winter Tucker				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Margaret Oliver			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 579-30-2493		17. INFORMANT husband Robert W. McCormick				ADDRESS same as 13e.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Respiratory Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Lung Cancer</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>7/17</u> 19 <u>86</u> to <u>6/13</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>5/15/87</u> 19 <u>87</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Vleve Larsen MD</u>				DEGREE _____				22c. DATE SIGNED <u>6.16.87</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Vleve Larsen				22e. ADDRESS 1234 19th Street, NW Washington, DC 20036							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE June 17, 1987		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood Pr George's MD					
24. FUNERAL DIRECTOR NAME Francis J. Collins				24b. ADDRESS 500 University Blvd., W Silver Spring, MD 20901				25a. DATE REC'D. BY REGISTRAR JUN 18 1987		25b. REGISTRAR'S SIGNATURE Julia Gordon-Randall	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FRANCIS

Film 8630 Item 5, 8/10/87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

37 18087

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Frances W. McDougall			2a. DATE OF DEATH MONTH DAY YEAR June 8, 1987			2b. HOUR 3:50 P.M.	
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR Feb. 20, 1919		6 AGE (IN YEARS LAST BIRTHDAY) 68 74 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Rhode Island		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Prince Georges County MD.	
10 CITY OR TOWN OF DEATH Laurel		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Greater Laurel Beltsville Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Academic Counselor		12b. KIND OF BUSINESS OR INDUSTRY American University	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Wheaton		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME Leonard J. Winsor		15. MOTHER'S MAIDEN NAME Amelia F. Corp.		13e. STREET ADDRESS / ZIP CODE 14138 Grand Pre Road 20906			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 038-03-6234		17. PLACE OF DEATH 19636 Wootton Ave. Poolesville, Md. 20837 Patricia A. McDougall (daughter-in-law)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiogenic shock</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Coronary artery disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <u>COPD, Rheumatoid arthritis</u>							
19a. DATE OF OPERATION N/A		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. N/A 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>5</u> 19 <u>87</u> to <u>present</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>6-8-</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Louis A. Casas MD</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 6-8-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) LUIS A CASAS MD				22e. ADDRESS 8317 CHERRY LA. LAUREL MD 20701			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 6/10/87		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory		23d. LOCATION Alexandria, Virginia STATE	
24. FUNERAL DIRECTOR NAME Tyson Wheeler Funeral Home, Inc. 1331 Rockville Pike, Rockville, Md. 20852				25a. DATE REC'D BY REGISTRAR JUN 15 1987		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 74 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18, show only injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST FRANCIS W. MCENTEE					2a. DATE OF DEATH MONTH DAY YEAR 06-26-87		2b. HOUR 11:30 A.M.		
3 SEX Male		4 RACE Caucasian		5 DATE OF BIRTH MONTH DAY YEAR Sept. 9, 1915		6 AGE (IN YEARS LAST BIRTHDAY) 71 YRS		7 UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Canada		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY MD.			
10 CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE'S HOSPITAL CENTER				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY US Gov't	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Maryland 13b COUNTY Pr. George's 13c CITY OR TOWN Bladensburg					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 4202 52nd St. 20710		
14 FATHER'S NAME FIRST MIDDLE LAST Harry McEntee			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emily Murray						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) WW II		17 INFORMANT Catherine S. McEntee same as 13e.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hrs.	
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>Acute Myocardial Infarction</u>									
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Coronary Artery Disease</u>									
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Cardiogenic Shock; Hypertension</u>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from <u>25 June 1987</u> to <u>26 June 1987</u> that (1) <u>was</u> lost saw the deceased alive on <u>26 June 1987</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above, (2) <u>did not</u> view the body after death.									
22b. SIGNATURE <u>Michael Schwartz</u>			DEGREE <u>M.D.</u>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>27 June 1987</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>MICHAEL SCHWARTZ, M.D.</u>			22e. ADDRESS <u>7500 Hanover Pkwy #103, Greenbelt, MD 20770</u>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>			23b. DATE <u>JUNE 29, 1987</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Brentwood, Pr. George's, MD</u>		
24. FUNERAL DIRECTOR NAME <u>Beall Funeral Home</u>			ADDRESS <u>16000 Annapolis Road Bowie, MD 20715-3043</u>			25a. DATE REC'D. BY REGISTRAR <u>JUL 02 1987</u>		25b. REGISTRAR'S SIGNATURE <u>William H. Jones</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.FOR
1- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) RUTH MCGEE			2a DATE OF DEATH MONTH DAY YEAR 06 05 87			2b HOUR M 6 30 PM				
3 SEX FEMALE		4 RACE CAUCASIAN		5 DATE OF BIRTH MONTH DAY YEAR Jan 5 1915			6 AGE (IN YEARS LAST BIRTHDAY) 72 YRS			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penna.		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES COUNTY MD			
10 CITY OR TOWN OF DEATH CHEVERLY		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGES HOSPITAL CENTER			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Capt. Rescue Worker			12b KIND OF BUSINESS OR INDUSTRY		
13a STATE Maryland			13b COUNTY Prince Geo. Capitol			13c CITY OR TOWN Hts.				
14 FATHER'S NAME FIRST MIDDLE LAST William A. McGee			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Minnie M. Bartlebaugh			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No			16b SOCIAL SECURITY NO. 579 84 0696			17 INFORMANT ADDRESS Grace Martin Same as 13E				
18 CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) CHRONIC OBSTRUCTIVE PULMONARY DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) GASTRO INTESTINAL BLEEDING								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:										
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE				
22a I certify that (I) (this hospital) attended the deceased from 5-25, 19-87, to 6-5, 19-87, that (I) (we) last saw the deceased alive on 6-4, 19-87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b SIGNATURE V. E. BINGH			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c DATE SIGNED 6-8-87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) V. E. BINGH			22e ADDRESS 5632 ANNAPOLIS RD #9 BLADENBURG Md 20712							
23a BURIAL, CREMATION, REMOVAL (SPECIFY) REMOVAL			23b DATE 6 JUNE 1987		23c NAME OF CEMETERY OR CREMATORY ALTO RESTE			23d LOCATION CITY OR TOWN COUNTY STATE ALLEGHENY TWP Blair Co. PA.		
24 FUNERAL DIRECTOR NAME Lloyd C. Smith			ADDRESS 414 N. JEWETT ST. HOLLIDAYSBURG, PA			25a DATE REC'D. BY REGISTRAR 11-11-87		25b REGISTRAR'S SIGNATURE John Davidson-Randall		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician a separate certificate should be filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 7 1 8 0 9 0

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) JOHN JOSEPH McGINNIS, Jr.			2a. DATE OF DEATH MONTH DAY YEAR June 11, 1987		2b. HOUR 6:52 A.M.
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR July 6, 1930		6. AGE (IN YEARS LAST BIRTHDAY) 56 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 72 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington DC	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD.	
10. CITY OR TOWN OF DEATH Lanham	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Doctors Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Accountant	12b. KIND OF BUSINESS OR INDUSTRY D.C. Gov't.	
13a. STATE Maryland			13b. COUNTY Prince Geo.	13c. CITY OR TOWN New Carrollton	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST John J. McGinnis, Sr.			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Eleanor Mc Rae		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes-Army Korean		16b. SOCIAL SECURITY NO 577-44-0608	17. INFORMANT Mary R. McGinnis, Same as Line #13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>cardiomyopathy</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>dissecting aortic aneurysm & coronary artery</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hr
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Hypertension</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>9-8-87</u> , 19 <u>87</u> , to <u>6-11-87</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>6-9-87</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.					
22b. SIGNATURE <u>Andres C. Lara</u>		DEGREE <u>MD</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 06-12-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Andres C. Lara		22e. ADDRESS 9326 Lanham Severn Road, Lanham, Md. 20706			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE June 12, 1987	23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria, Virginia
24. FUNERAL DIRECTOR FRANCIS GASCH'S SONS FUNERAL HOME, P.A. 4739 Baltimore Ave., Hyattsville, Maryland			25a. DATE REC'D. BY REGISTRAR JUN 17 1987		

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THE UNIVERSITY OF CHICAGO
DIVISION OF THE PHYSICAL SCIENCES
DEPARTMENT OF CHEMISTRY
CHICAGO, ILLINOIS 60637

TO: [illegible]
FROM: [illegible]
SUBJECT: [illegible]
DATE: [illegible]
[illegible text follows]

[illegible text follows]

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 18091

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) SAMUEL B. MCLAUGHLIN			2a. DATE OF DEATH MONTH DAY YEAR 06 01 87		2b. HOUR MIN. 12 30PM		
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Oct. 26 1921		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 65	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Mexico		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S	
10. CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION PRINCE GEORGE'S HOSPITAL CENTER		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) U.S. Capitol Police		12b. KIND OF BUSINESS OR INDUSTRY U.S. Capitol	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland				13b. COUNTY Prince George Forest Hgts.		13c. CITY OR TOWN Forest Hgts.	
14. FATHER'S NAME FIRST MIDDLE LAST William S. McLaughlin				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maria Juevera			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII 526-05-3746		17. INFORMANT ADDRESS Patricia A. McLaughlin 5903 Summer Lane Forest Heights, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary Arrest; Coma DUE TO, OR AS A CONSEQUENCE OF (b) Acute Cerebral Hemorrhage DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. a Hypertension							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) this hospital attended the deceased from 5-31-1987 to 6-1-1987 that (I) last saw the deceased alive on 6-1-1987 , and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) will did not view the body after death.							
22b. SIGNATURE G. M. DIN, M.D.				DEGREE M.D.		22c. DATE SIGNED 6/2/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) G. M. DIN, M.D.				22e. ADDRESS 6510 Kamilworth Ave, Suite 2600 Riverdale M.D. 20737			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6/4/87		23c. NAME OF CEMETERY OR CREMATORY Resurrection Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Clinton P.G. Maryland	
24. FUNERAL DIRECTOR NAME George P. Kalas Funeral Home				ADDRESS 6160 Oxon Hill Rd. Oxon Hill, Md.		25a. DATE REC'D. BY REGISTRAR JUN 5 1987	
				25b. REGISTRAR'S SIGNATURE [Signature]			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked, item 18 shows any injury, or other traumatic event, the medical examiner must be notified or called.

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JUN 1987

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8718092

REG. NO.

1- FOR
STATE
REGISTRAR

1- DECEASED NAME (TYPE OR PRINT) Catherine V. McMahan			2a DATE OF DEATH MONTH DAY YEAR June 27, 1987		2b HOUR 6:00a M
3 SEX Female	4 RACE Caucasian	5 DATE OF BIRTH Sept. 16, 1922	6 AGE (IN YEARS LAST BIRTHDAY) 64	7b CITIZEN OF WHAT COUNTRY? U.S.A.	
7a BIRTHPLACE Maryland	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD		
10 CITY OR TOWN OF DEATH Ft. Washington	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION 6603 Farmer Drive		12a USUAL OCCUPATION homemaker	12b KIND OF BUSINESS OR INDUSTRY home	
13a STATE Maryland	13b COUNTY Prince George's	13c CITY OR TOWN Ft. Washington	13d INSIDE CITY LIMITS? <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e STREET ADDRESS / ZIP CODE 6603 Farmer Drive 20744	
14 FATHER'S NAME Walter Hancock		15 MOTHER'S MAIDEN NAME Julia Wood			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no	16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) n/a	17 INFORMANT (husband) Robert C. McMahan		ADDRESS same as 13 a-e	
18 CAUSE OF DEATH Enter only one cause per line for a, b, and c. PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>infectious</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last } b) <u>metastatic breast cancer</u> DUE TO, OR AS A CONSEQUENCE OF c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION CITY OR TOWN COUNTY STATE	
22a I certify that (1) this hospital attended the deceased from <u>June 27</u> to <u>June 27</u> 19 <u>87</u> , that (1) we lost saw the deceased alive or <u>buried</u> <u>MD</u> and that in my own opinion death occurred on the date and hour and from the causes stated above. (I we) did not view the body after death.					
22b SIGNATURE <u>David J. Nardak</u>		DEGREE <u>MD</u>		22c DATE SIGNED <u>6/29/87</u>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) DAVID J. NARDAK M.D.		22e ADDRESS 8926 Woodyard Ste 201 Clinton Md. 20735			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b DATE June 29, 1987	23c NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d LOCATION CITY OR TOWN COUNTY STATE Suitland, Prince George's Md	
24 FUNERAL DIRECTOR NAME Lee Funeral Home, Inc.		25a DATE REC'D. BY REGISTRAR JUL 01 1987		25b REGISTRAR'S SIGNATURE <u>Julia Davidson-Russell</u>	
25c ADDRESS Old Alexander Ferry Rd., Clinton, MD 20735					

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon appropriate to page 2 and 3 and file within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition. This is a legal requirement. If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once. IMPORTANT.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- STATE REGISTRAR									
1 DECEASED NAME (TYPE OR PRINT)						2a DATE OF DEATH			
Floyd Edward McPhearson						6 29 87 8 ⁴⁵ PM			
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		7b HOUR	
Male		White		Feb 26 1908		79 YRS			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH			
Washington DC		USA				Prince George MD			
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY	
Clinton		Southern Maryland MED Center				Division Chief		Library of Congress	
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b STATE		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET ADDRESS / ZIP CODE	
Maryland		Pr Geo		Suitland		YES <input type="checkbox"/> NO <input type="checkbox"/>		4126 Suitland Road 20746	
14 FATHER'S NAME		15 MOTHER'S MAIDEN NAME							
Floyd Edward McPhearson SR		Emma Elizabeth Tucker							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO		17 INFORMANT ADDRESS					
No		113 32 5681		Audrey W McPhearson Same as #13					
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Cerebral vascular accident</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Diabetes mellitus</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>20 years</u>									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u></u>									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY?		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
				21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from <u>7/1</u> , 19 <u>86</u> to <u>6/29</u> , 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>6/29</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE <u>William J Oetgen</u>				DEGREE				22c DATE SIGNED	
				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				6/30/87	
22d PHYSICIAN'S NAME (TYPE OR PRINT)				22e ADDRESS					
William J Oetgen, M.D.				4341 Branch Ave Temple Hills, MD.					
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION CITY OR TOWN COUNTY STATE			
Burial		2 July 1987		Washington National Cemetery		Suitland PG			
24 FUNERAL DIRECTOR NAME				ADDRESS		25a DATE REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE	
Robert E Wilhelm				Suitland, Maryland		JUL 06 1987		Julia Davidson-Randall	

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1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

87 18094

1. DECEASED NAME (TYPE OR PRINT) FIRST MARY MIDDLE HARRIS LAST MCWILLIAMS			2a. DATE OF DEATH MONTH DAY YEAR 06 19 87		2b. HOUR 9:34PM
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR June 6, 1914		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES COUNTY MD.	
10. CITY OR TOWN OF DEATH CHEVERLY	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGES HOSPITAL CENTER		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Prof. Cook		12b. KIND OF BUSINESS OR INDUSTRY Restaurants
13a. STATE Virginia		13b. COUNTY	13c. CITY OR TOWN Winchester	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 96 Molden Drive 99999
14. FATHER'S NAME FIRST MIDDLE LAST George Francis Harris		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elba Silber Harris			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 234-10-5241		17. INFORMANT ADDRESS Jeanette Gross, 96 Molden Dr., Winchester, VA	

18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) Malignant Lymphoma of Brain

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b) _____
DUE TO, OR AS A CONSEQUENCE OF

(c) _____

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

5 yrs

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:0

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from <u>6/19</u> , 19 <u>87</u> , to <u>6/19</u> , 19 <u>87</u> , that (1) (we) lost saw the deceased <u>above</u> , (1) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Don H. Yablonsky</u>		DEGREE <u>MD</u>		22c. DATE SIGNED <u>6/20/87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Don H. Yablonsky, MD</u>		22e. ADDRESS <u>10300 Greenbelt Rd., Seabrook, Md</u>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE June 27, 1987	23c. NAME OF CEMETERY OR CREMATORY Sacred Heart Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Winchester, Virginia 22601
24. FUNERAL DIRECTOR NAME <u>Jerry B. Giffin</u> ADDRESS GIFFIN FUNERAL HOME, CAYON BRIDGE, WV 26711		25a. DATE REC'D. BY REGISTRAR JUN 26 1987	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The funeral director should remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene. The funeral director should also remove carbon papers. The funeral director should remove carbon papers. The funeral director should remove carbon papers.

IMPORTANT: If item 21 is marked or item 18 shows any other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 18095

1- FOR STATE REGISTRAR		2a DATE OF DEATH		MONTH	OAT	YEAR	2b HOUR
1 DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE	LAST		
LILLIAN		M.		MERSON			
3 SEX	4 RACE	5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		7b HOUR	
female	white	July 25 1907		85		4:37 P	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH			
Maryland	USA			PRINCE GEORGE COUNTY MD.			
10 CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY		
Laurel	GREATER LAUREL BELTSVILLE HOSPITAL		cafeteria worker		elem. school		
13a STATE	13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS?	13e STREET ADDRESS / ZIP CODE			
Maryland	P.G.	Laurel	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	10 Riverview Ct. 20707			
14 FATHER'S NAME (FIRST MIDDLE LAST)		15 MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST)					
August Lewis Wossowski		Emma Jane Kruhm					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO.		17 INFORMANT ADDRESS			
no		213-05-8325		Phyllis Mills 9621 Baltimore Ave Laurel, Maryland 20707			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
887 IMMEDIATE CAUSE (a) Myocardial infarct							
DUE TO, OR AS A CONSEQUENCE OF							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							
DUE TO, OR AS A CONSEQUENCE OF							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:							
recent hip fracture with repair							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		19c AUTOPSY?		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
5/22/87				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
		P.M. 19					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from above, (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE DEGREE							
22c DATE SIGNED							
22d PHYSICIAN'S NAME (TYPE OR PRINT)							
22e ADDRESS							
23a BURIAL, CREMATION, REMOVAL (SPECIFY)							
23b DATE							
23c NAME OF CEMETERY OR CREMATORY							
23d LOCATION CITY OR TOWN COUNTY STATE							
24 FUNERAL DIRECTOR							
25a DATE REC'D. BY REGISTRAR							
25b REGISTRAR'S SIGNATURE							

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 18096
REG. NO.1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Mary Elizabeth MICHAELS			2a. DATE OF DEATH MONTH DAY YEAR June 14, 1987		2b. HOUR 1:28 A.M.
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR NOV. 13, 1927		6. AGE (IN YEARS LAST BIRTHDAY) 59 YRS	7. UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PUERTO RICO	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD.	
10. CITY OR TOWN OF DEATH Lanham	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Doctors' Hospital of Pr. Geo. Co.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) NURSING AID.	12b. KIND OF BUSINESS OR INDUSTRY NURSING	
13a. STATE Md.	13b. COUNTY P.G.C.	13c. CITY OR TOWN BELTSVILLE	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 4403 ROMLON ST. #203, 20705	
14. FATHER'S NAME FIRST MIDDLE LAST ALFRED DORANCE CHICKERING		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST DOROTHY HART			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 567-38-8564		17. INFORMANT ADDRESS KATHERYN C. MICHAELS (SAME AS ITEM #13)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Recurrent Squamous Cell Cancer</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Esophageal Cancer</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>8</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Squamous Cell Cancer Pharynx + Tongue</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 19 <u>86</u> to <u>6/14</u> 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>6/13</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Berard</u>		DEGREE		22c. DATE SIGNED <u>6/14/87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BERARD		22e. ADDRESS 710 Baltimore Ave #1 College Park Md 20740			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION	23b. DATE 6-15-1987	23c. NAME OF CEMETERY OR CREMATORY CHAMBERS CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE RIVERDALE, P.G.C. Md.	
24. FUNERAL DIRECTOR NAME W. W. CHAMBERS CO.		ADDRESS RIVERDALE, Md. 20737		25a. DATE REC'D. BY REGISTRAR JUN 23 1987	25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this page to the State Dept. of Health and Mental Hygiene, 201 W. Preston St., Baltimore, Md. 21201. IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

OFFICE OF THE SECRETARY

OF THE ARMY

WASHINGTON, D.C. 20315

OFFICE OF THE SECRETARY

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 8718091

1. DECEASED NAME (TYPE OR PRINT) DORIS MARIE MILBURN			2a. DATE OF DEATH MONTH DAY YEAR 6/12/87			2b. HOUR 6:29 PM			
3 SEX FEMALE		4 RACE CAUCASIAN		5 DATE OF BIRTH MONTH DAY YEAR NOV. 25, 1913		6 AGE (IN YEARS LAST BIRTHDAY) 73		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON, D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Prince Georges Co. MD.			
10 CITY OR TOWN OF DEATH Clinton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Maryland Hosp				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CLERK		12b. KIND OF BUSINESS OR INDUSTRY CIVIL SERVICE	
13a. STATE MARYLAND		13b. COUNTY ST. MARY'S		13c. CITY OR TOWN MECHANICSVILLE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE RT. #1, BOX 414 20659	
14. FATHER'S NAME FIRST MIDDLE LAST FRANK BENJAMIN HAVENS				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CORNELIA DODGE					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 229-32-9673		17. INFORMANT PATRICIA GODWIN, MECHANICSVILLE, MD. 20659					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIORESPIRATORY FAILURE DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) AORTIC Aneurysm. E DUE TO, OR AS A CONSEQUENCE OF (c) Renal failure APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 48°									
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a Multiple associated medical problems.									
19a. DATE OF OPERATION 6/9		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Aortic Aneurysm.				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 7501 Surratt Rd Clinton Md					
22a. I certify that (I) (this hospital) attended the deceased from 6/12/87 19 87 to 6/12 19 87 that (I) (we) lost saw the deceased alive on 6/12 19 87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (Initials and) (and not) view the body after death.									
22b. SIGNATURE Gary Grover				DEGREE MD		ATTENDING MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 6/13/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Gary Grover, MD				22e. ADDRESS 7501 Surratt Rd Clinton Md					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 6/16/87		23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL		23d. LOCATION CITY OR TOWN COUNTY STATE ARLINGTON, ARLINGTON, VA.			
24. FUNERAL DIRECTOR NAME ADDRESS EDWARD N. BRINSFIELD, JR., LEONARDTOWN, MD.				25a. DATE REC'D. BY REGISTRAR JUN 16 1987		25b. REGISTRAR'S SIGNATURE Julia Swinton-Randall			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

1. The first part of the report is a general description of the project. It includes the title, the objectives, the scope, and the methodology.

2. The second part of the report is a detailed description of the results. It includes the data, the analysis, and the conclusions.

3. The third part of the report is a discussion of the results. It includes the interpretation of the results, the limitations of the study, and the recommendations for future research.

4. The fourth part of the report is a conclusion. It summarizes the main findings of the study and provides a final statement on the project.

5. The fifth part of the report is a list of references. It includes the sources of information used in the study.

6. The sixth part of the report is an appendix. It includes additional information that is not included in the main body of the report.

7. The seventh part of the report is a glossary. It includes definitions of the terms used in the report.

8. The eighth part of the report is a list of figures. It includes the titles of the figures and the pages on which they are located.

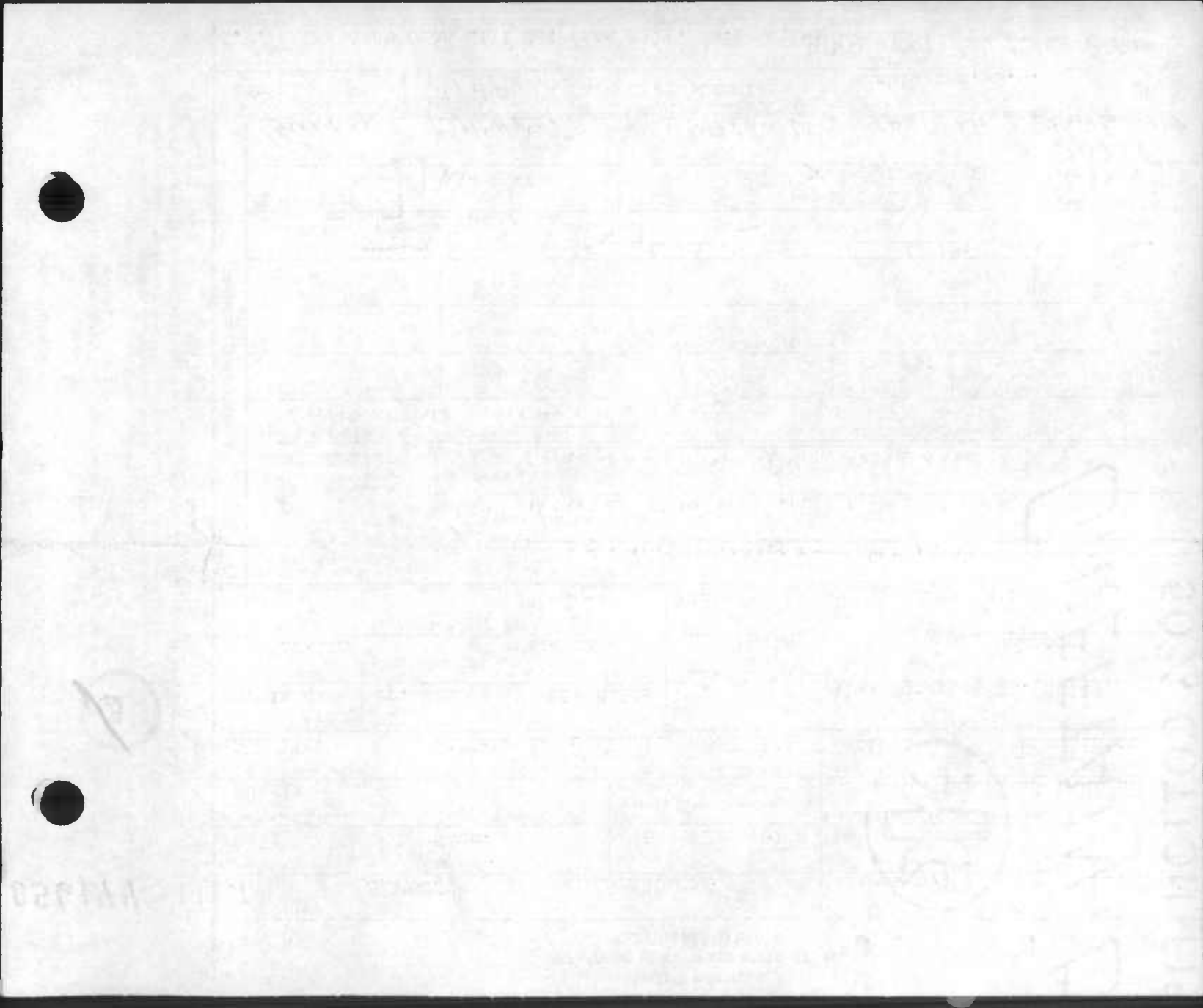
9. The ninth part of the report is a list of tables. It includes the titles of the tables and the pages on which they are located.

10. The tenth part of the report is a list of abbreviations. It includes the abbreviations used in the report and their full names.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 18098
REG. NO.FOR
1 - STATE
REGISTRAR

1. DECEASED NAME (Type or Print) SERGIJ MISHCHENKO		2a. DATE OF DEATH MONTH DAY YEAR 6-4-87		2b. HOUR 1:25 P.M.	
3. SEX Male	4. RACE Cauc.	5. DATE OF BIRTH MONTH DAY YEAR 6 22 07		6. AGE (IN YEARS LAST BIRTHDAY) 79	7. YRS. MONTHS DAYS HOURS MIN.
8a. BIRTHPLACE COUNTRY Russia	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES COUNTY MD.	
10. CITY OR TOWN OF DEATH CLINTON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SOUTHERN MARYLAND HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY Machinist
13a. STATE Maryland	13b. COUNTY Pr. George	13c. CITY OR TOWN Temple Hills	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 4103 Norcross St. 20748	
FATHER'S NAME FIRST MIDDLE LAST Markian Mischenko		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maria Unknown			
14a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no		14b. SOCIAL SECURITY NO. 084-26-4216		17. INFORMANT ADDRESS Klavdia Mishchenko same as item 13	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) ACUTE MYOCARDIAL INFARCTION					
DUE TO, OR AS A CONSEQUENCE OF (c) CORONARY ARTERY DISEASE					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) CONGESTIVE HEART FAILURE					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) this hospital attended the deceased from 6/2 19 87 to 6/19 19 87 that I lost saw the deceased alive on above, (2) I did not view the body after death.					
22b. SIGNATURE <i>S. Anselm</i>		DEGREE		22c. DATE SIGNED 6/14/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Ben Box NAETHALANI		22e. ADDRESS 8926 Woodyard Rd Clinton MD		22f. PHYSICIAN'S NAME (TYPE OR PRINT) Ben Box NAETHALANI	
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE 6/6/87		23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D.C.		25a. DATE REC'D. BY REGISTRAR JUN 9 1987			
24. FUNERAL DIRECTOR NAME ADDRESS G.P. Kalas 6160 Oxon Hill Rd. Oxon Hill, Md.		25b. REGISTRAR'S SIGNATURE <i>Julia Gordon-Randall</i>			



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8718099
REG. NO.1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) CARMENA H. A/K/A SANDERS MITCHELL		2a. DATE OF DEATH MONTH DAY YEAR JUNE 21 87		2b. HOUR 8:36 am	
3. SEX FEMALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR MAY 13, 1914	
6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS		7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) SOUTH CAROLINA		8. CITIZEN OF WHAT COUNTRY? U.S.A.	
9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S MD.		10. CITY OR TOWN OF DEATH CAMP SPRINGS		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MALCOLM GROW USAFMC	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) L.P.N.		12b. KIND OF BUSINESS OR INDUSTRY V.A. HOSPITAL		13a. STATE NEW YORK	
13b. COUNTY SUFFOLK		13c. CITY OR TOWN WYANDANCH		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE 186 BOOKER AVE. 11798		14. FATHER'S NAME FIRST MIDDLE LAST MALCOLM HALYARD		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNK.	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. W.W. II 125-16-5222		17. INFORMANT (husband) ADDRESS HUGHES ROBERT MITCHELL SAME AS 13 a - e	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). <u>CARDIOPULMONARY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b). <u>BLADDER CANCER PROBABLY METASTATIC</u> DUE TO, OR AS A CONSEQUENCE OF (c). PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (I) this hospital attended the deceased from <u>14 JUNE 19 87</u> to <u>21 JUNE 19 87</u> , that (II) (we) last saw the deceased alive on <u>21 JUNE 19 87</u> , and that (III) (our) opinion death occurred on the date and hour and from the causes stated above (If we last did not saw the body after death).			
22b. SIGNATURE <u>Brian D. Johnson</u> MD		22c. DATE SIGNED 22 JUNE 87		22d. ADDRESS MALCOLM GROW USAF MEDCEN AAFB, MD 20331-5300	
23a. BURIAL, CREMATION, REMOVAL, ETC. (SPECIFY) Burial		23b. DATE June 26, 1987		23c. NAME OF CEMETERY OR CREMATORY CALVERTON NATIONAL	
23d. LOCATION CITY OR TOWN COUNTY STATE AMITYVILLE, SUFFOLK, NEW YORK		24. FUNERAL DIRECTOR (NAME) Lee Funeral Home, Inc. Old Alexander Ferry Rd., Clinton, MD 20735			

MEDICAL CERTIFICATION

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 18100

1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) May Mitchell			20. DATE OF DEATH June 11, 1987			2b. HOUR 5:05 PM				
3. SEX Female			4. RACE White			5. DATE OF BIRTH May 15 1900				
6. BIRTHPLACE England			7b. CITIZEN OF WHAT COUNTRY? England			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				
9. CITY OR TOWN OF DEATH Baltimore			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NO IN-FACILITY, GIVE STREET ADDRESS) Doctors Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker				
12b. KIND OF BUSINESS OR INDUSTRY Home			13a. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13b. STREET ADDRESS / ZIP CODE 7 Southgate Ct. 21101				
14. FATHER'S NAME Richard Rule			15. MOTHER'S MAIDEN NAME Mary Mitchell			16. SOCIAL SECURITY NO. #13				
17. INFORMANT Beryl A. McAteer			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral arrest</u> DUE TO, OR AS A CONSEQUENCE OF: (b) <u>Cerebral infarction</u> DUE TO, OR AS A CONSEQUENCE OF: (c) <u>Arteriosclerosis and disease</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 months</u> <u>2 days</u> <u>3 months</u>				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I), (this hospital) attended the deceased from <u>1985</u> , 19 <u>85</u> , to <u>6/11/87</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>6/11/87</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Leon R. Levitsky</u>			DEGREE M.D.			22c. DATE SIGNED 6/11/87				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Leon R. Levitsky M.D.			22e. ADDRESS P. O. Box 626, Riverdale, Md. 20737							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 6-12-87			23c. NAME OF CEMETERY OR CREMATORY Cedar Hill			23d. LOCATION CITY OR TOWN COUNTY STATE Suttsford PG Md.	
24. FUNERAL DIRECTOR NAME 1740r Funeral Chapel			ADDRESS Annapolis, Md.			25a. DATE REC'D. BY REGISTRAR JUN 18 1987			25b. REGISTRAR'S SIGNATURE Julia Swenson-Randall	

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

8101

1- FOR STATE REGISTRAR		2a DATE KNOWN OF DEATH		2b HOUR	
1 DECEASED NAME (TYPE OR PRINT) KATHERINE MONTAGUE		MONTH DAY YEAR 6 22 1987		8:22 PM	
3 SEX F	4 RACE can	5 DATE OF BIRTH MONTH DAY YEAR 11 8 16 70	6 AGE (IN YEARS) LAST BIRTHDAY 70 YRS.	7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MINNESOTA	7b CITIZEN OF WHAT COUNTRY? USA
8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Prince George's		MD	
10 CITY OR TOWN OF DEATH Laurel		11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Greater Laurel Beltsville Hosp		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) WEAVER	
12b KIND OF BUSINESS OR INDUSTRY SELF-EMPLOYED		13a STATE MD		13b COUNTY Prince Georges	
13c CITY OR TOWN Beltsville		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS 4424 Romlon Street	
14 FATHER'S NAME FIRST HARRY MIDDLE J. LAST BAKER		15 MOTHER'S MAIDEN NAME FIRST MARY MIDDLE GERMSHIED LAST 20705		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO	
16b SOCIAL SECURITY NO. 577-26-4939		17 INFORMANT RICK BROOKS		ADDRESS SAME AS ABOVE	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF (c) years					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I none					
19a DATE OF OPERATION none		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?		20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) none	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f LOCATION CITY OR TOWN COUNTY STATE	
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .					
ACTUAL SIGNATURE Paul A. DeVore		TITLE (SPECIFY) M.D. Deputy		DATE SIGNED 6-22-87	
EXAMINER'S NAME (TYPE OR PRINT) PAUL A. DEVORE MD		ADDRESS 4203 Queensbury Rd Hyattsville MD			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b DATE 6/24/87		23c NAME OF CEMETERY OR CREMATORY WESTVIEW MEMORIAL CATHOLIC	
23d LOCATION CITY OR TOWN COUNTY STATE MD		24 FUNERAL DIRECTOR NAME DONALDSON FUNERAL HOME ADDRESS LAUREL MD		25a DATE REC'D. BY REGISTRAR JUN 29 1987	
25b REGISTRAR'S SIGNATURE Paul A. DeVore					

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. BOSTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS 201 W. BOSTON ST., BALTIMORE, MD. 21201

COPIES OF THE ORIGINAL

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove and file in the State Dept. of Health and Mental Hygiene prior to burial, cremation, removal, or other disposition of the body. **IMPORTANT:** If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		2a. DATE OF DEATH				2b. HOUR					
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH				2b. HOUR					
ROBERT C. MORTON		06-24-87				11:40AM					
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE		7. UNDER 1 YEAR		7. UNDER 23 HRS			
MALE	NEGRO	SEPTEMBER 12, 1904		82 YRS		MONTHS		DAYS			
7a. BIRTHPLACE (COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		10. MONTHS		10. DAYS			
DC	USA	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		PRINCE GEORGE'S COUNTY		HOURS		MIN.			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION		12a. USUAL OCCUPATION		12b. KIND OF BUSINESS OR INDUSTRY		13. MONTHS		13. DAYS		
CHEVERLY	GLADYS NOON SPELLMAN NUR. CARE CTR.		CHAUFFEUR		US GOV'T		HOURS		MIN.		
13a. STATE		13b. CITY OR TOWN		13c. STREET ADDRESS / ZIP CODE		14. MONTHS		14. DAYS		14. HOURS	
DC		WASHINGTON		1343 A STREET, N.E.		99999		HOURS		MIN.	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16. SOCIAL SECURITY NO.		17. INFORMANT		18. ADDRESS		19. CITY OR TOWN	
UNK		MOLLIE UNK		578-09-3577		robert morton-GRANDSON		1343 A St., N.E.		99999	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT		18. ADDRESS		19. CITY OR TOWN		20. STATE	
NO		578-09-3577		robert morton-GRANDSON		1343 A St., N.E.		99999		99999	
21. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio Pulmonary arrest</u>											
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Possible Pneumonia</u>											
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Possible Sepsis</u>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>old cardiovascular accident, gastroenteric feeding tube</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		21. CITY OR TOWN		21. STATE	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED		21d. LOCATION		21e. PLACE OF INJURY		21f. LOCATION	
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		HOUR A.M. MONTH DAY YEAR		(ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)		CITY OR TOWN		COUNTY		STATE	
(IF EITHER NOTIFY MEDICAL EXAMINER)		P.M.		19		STREET		CITY OR TOWN		STATE	
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION		21g. LOCATION		21h. LOCATION		21i. LOCATION	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		(AT HOME STREET FACTORY OFFICE FARM ETC.)		STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>10-15, 1987</u> to <u>6-24, 1987</u> that (I) (we) last saw the deceased alive on <u>6-24, 1987</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		22f. ADDRESS		22g. ADDRESS	
R. POPE		6/24/87		ALEXANDER S. POPE		2617 PA. AVE., S.E. D.C.		JUL 06 1987		Julia Gordon-Pope	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		23e. LOCATION		23f. LOCATION	
BURIAL		7-1-87		LINCOLN CEMETERY		SUITLAND, PG, MARYLAND		SUITLAND, PG, MARYLAND		SUITLAND, PG, MARYLAND	
24. FUNERAL DIRECTOR		25a. DATE REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		25c. REGISTRAR'S SIGNATURE		25d. REGISTRAR'S SIGNATURE		25e. REGISTRAR'S SIGNATURE	
ALEXANDER S. POPE		JUL 06 1987		Julia Gordon-Pope		Julia Gordon-Pope		Julia Gordon-Pope		Julia Gordon-Pope	

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DHMH - 16 60M 7/84
(VRA 15, 4)

Mr.

Mr. J. H. ...

Mr. J. H. ...

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 28 shows any injury, or other traumatic event, the medical examiner must be called out at once.STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 18103

1. DECEASED NAME (TYPE OR PRINT) CATHERINE Mary MOORE			2a. DATE OF DEATH MONTH DAY YEAR 6 1 87		2b. HOUR MIN. 5:00 A
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR July 9, 1907		6. AGE (IN YEARS LAST BIRTHDAY) 79	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD.	
10. CITY OR TOWN OF DEATH Largo	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Manor Care Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Director of		12b. KIND OF BUSINESS OR INDUSTRY C&P Telephone Company
13a. STATE Maryland	13b. COUNTY P.G.	13c. CITY OR TOWN N. Hyattsville	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 3317 Penn Street 20783	
14. FATHER'S NAME FIRST MIDDLE LAST Thomas J. Gallagher			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lillian McInnis		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 577-01-1962		17. INFORMANT ADDRESS Catherine D. Slagle (Daughter) Lanham, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Complications of surgery DUE TO, OR AS A CONSEQUENCE OF (c) 1 year.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 1 year.					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (the hospital) attended the deceased from 5-16 19 87 to 6-1 19 87 that (I) last saw the deceased alive on 5-16 19 87 , and that in (my) own opinion death occurred on the date and hour and from the causes stated above; (b) we did not view the body after death.					
22b. SIGNATURE Seruch t. Kimble M.D.				22c. DATE SIGNED June 1, 1987	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Seruch t. Kimble				22e. ADDRESS 9801 Georgia Ave., Silver Spring, Md. 20902	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 06/04/87	23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D.C.		
24. FRANK J. GASCH'S SONS FUNERAL HOME, P.A. NAME ADDRESS 4739 Baltimore Ave., Hyattsville, Maryland			25a. DATE RECEIVED BY REGISTRAR JUN 4 1987		25b. REGISTRAR'S SIGNATURE Julia Decker-Kendall

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DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 7 1 8 1 0 4
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Harold B. Moore			2a. DATE OF DEATH MONTH DAY YEAR June 2, 1987		2b. HOUR 2 P.M.
3. SEX Male	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR March 24, 1910		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) S.C.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD.		
10. CITY OR TOWN OF DEATH Forestville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 6104 Surrey Square # 101		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret.-Sp. Police		12b. KIND OF BUSINESS OR INDUSTRY Security
13a. STATE Md.	13b. COUNTY P.G.	13c. CITY OR TOWN Forestville	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 6104 Surrey Square # 101 20747	
14. FATHER'S NAME FIRST MIDDLE LAST Simms Moore		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Simmia Hill			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II	17. INFORMANT ADDRESS Doris Moore-914 Div. Ave., N.E., D.C.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorespiratory Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Metastatic Colon Cancer DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. (c)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (the hospital) attended the deceased from MAY 10 1987 to JUNE 2 1987 , that (I) (we) last saw the deceased alive on MAY 3 1987 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (we did not) view the body after death.					
22b. SIGNATURE M. M. Kandahari				22c. DATE SIGNED 6-4-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MASOOM KANDAHARI, M.D.				22e. ADDRESS 611 S. CARLIN SPRINGS RD, ARLINGTON, VA	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE 6/9/87	23c. NAME OF CEMETERY OR CREMATORY QUANTICO NAT'L. CEM.		23d. LOCATION CITY OR TOWN COUNTY STATE QUANTICO, VA.	
24. FUNERAL DIRECTOR (NAME) H. S. WASHINGTON + SONS				25a. DATE REC'D. BY REGISTRAR JUN 18 1987	25b. REGISTRAR'S SIGNATURE Julia Gordon-Randall

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OFFICE OF THE SECRETARY

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it is to be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper inserts, and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, a medical examiner must be notified and a medical certification completed.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO.		8718105					
1. DECEASED NAME (TYPE OR PRINT) FIRST MARIAN T. MIDDLE MORAN LAST				2a. DATE OF DEATH MONTH DAY YEAR 6-8-87				2b. HOUR 3:50a.m.	
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR May 23 1932		6. AGE (IN YEARS LAST BIRTHDAY) 55 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Italy		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES CO. MD.			
10. CITY OR TOWN OF DEATH CLINTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. MARYLAND Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Collecting Agent		12b. KIND OF BUSINESS OR INDUSTRY Collection	
13a. STATE Maryland		13b. COUNTY Prince George		13c. CITY OR TOWN Temple Hills		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 3804 Spring Terrace 20748	
14. FATHER'S NAME FIRST Vincent MIDDLE LAST Fazzolari		15. MOTHER'S MAIDEN NAME FIRST Giovanni MIDDLE LAST Unknown							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 235-48-9637		17. INFORMANT ADDRESS 3804 Spring Terrace Michael J. Moran Temple Hills, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Squamous cell cancer of the tongue with cervical lymph node metastasis 10 mos DUE TO, OR AS A CONSEQUENCE OF b) DUE TO, OR AS A CONSEQUENCE OF c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (the hospital) attended the deceased from April 19 87 to June 19 87 that (I) (the doctor) saw the deceased alive on 6-6-87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (we) did not view the body after death.									
22b. SIGNATURE Kai-Yiu Yeung, M.D.		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 6-8-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Kai-Yiu Yeung, M.D.				22e. ADDRESS 8726 Woodyard Rd #201 Clinton, MD 20735					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6/11/87		23c. NAME OF CEMETERY OR CREMATORY Resurrection Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Clinton P.G. Maryland			
24. FUNERAL DIRECTOR NAME George P. Kalas Funeral Home				6160 Oxon Hill Rd. Oxon Hill, Md.		25a. DATE REC'D. BY REGISTRAR JUN 10 1987		25b. REGISTRAR'S SIGNATURE [Signature]	

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DEATH IS SUSPECTED, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 4 TO THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 4 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL, TRANSIT PERMIT, PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 18106

1. DECEASED NAME (Type in full)		FIRST PEGGY		MIDDLE C.		LAST MUNAL		2a. DATE KNOWN OF DEATH ESTI- MATED <input checked="" type="checkbox"/> MONTH DAY YEAR June 3 19 87		2b. HOUR M 10a.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR July 9, 1941		6. AGE (IN YEARS) LAST BIRTHDAY 45 YRS.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR June 3 19 87		7d. HOUR M 10a.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Kentucky		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges		12b. KIND OF BUSINESS OR INDUSTRY Law		MD.	
10. CITY OR TOWN OF DEATH Bowie		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SURVIVAL FACTS, GIVE STREET ADDRESS) 12616 Heming Lane		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary		12c. KIND OF BUSINESS OR INDUSTRY Law					
13a. STATE Washington D.C.		13b. COUNTY Wash.D.C.		13c. CITY OR TOWN Wash.D.C.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2400 Virginia Avenue N.W.		99922034	
14. FATHER'S NAME FIRST MIDDLE LAST Marlitt Combs		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lorna Thacker		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 405-56-0894		17. INFORMANT Patricia C. Spisso		ADDRESS Fairfax Sta., Va. 11735 Lakewood Lane	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchogenic carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under-lying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE Augusto P. Rodriguez		TITLE Deputy		M.D.		MEDICAL EXAMINER		DATE SIGNED 6-4-86			
EXAMINER'S NAME (TYPE OR PRINT) Augusto P. Rodriguez, M.D.		ADDRESS 5009 Rayburn Ct, Temple Hills, MD									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE June 6 1987		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria, Virginia					
24. FUNERAL DIRECTOR NAME Beall Funeral Home		ADDRESS 16000 Annapolis Road Bowie, Maryland		25a. DATE REC'D BY REGISTRAR JUN 10 1987		25b. REGISTRAR'S SIGNATURE J. J. J. J.					

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